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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: PMXR

Facility ID: 00101

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245250**
2.STATE VENDOR OR MEDICAID NO.
(L2) **866245200**

3. NAME AND ADDRESS OF FACILITY
(L3) **TRINITY CARE CENTER**
(L4) **3410 213TH STREET WEST**
(L5) **FARMINGTON, MN** (L6) **55024**

4. TYPE OF ACTION: **7** (L8)
1. Initial 2. Recertification
3. Termination 4. CHOW
5. Validation 6. Complaint
7. On-Site Visit 9. Other
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9) **09/29/2003**

6.IATEIOFISURVEY **12/28/2017** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **65** (L18)
13.Total Certified Beds **65** (L17)

10.THE FACILITY IS CERTIFIED AS:
x A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

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

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

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	65			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Eva Loch, Unit Supervisor 2/20/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 3/9/2018 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
07/20/1982
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

CMS Certification Number (CCN): 245250

February 20, 2018

Ms. Elizabeth Letich, Administrator
Trinity Care Center
3410 213th Street West
Farmington, MN 55024

Dear Ms. Letich:

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

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

Effective December 13, 2017 the above facility is certified for:

65 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 65 skilled nursing facility beds.

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

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

Please contact me if you have any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Licensing and Certification Program
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

cc: Licensing and Certification File

Electronically delivered
February 20, 2018

Ms. Elizabeth Letich, Administrator
Trinity Care Center
3410 213th Street West
Farmington, MN 55024

RE: Project Number S5250027

Dear Ms. Letich:

On December 5, 2017, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on November 16, 2017. This survey found the most serious deficiencies to be a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E) whereby corrections were required.

On December 28, 2017, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on December 19, 2017 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on November 16, 2017. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of December 13, 2017. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on November 16, 2017, effective December 13, 2017 and therefore remedies outlined in our letter to you dated December 5, 2017, will not be imposed.

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Licensing and Certification Program
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

cc: Licensing and Certification File

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: PMXR

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(L3) **TRINITY CARE CENTER**
(L4) **3410 213TH STREET WEST**
(L5) **FARMINGTON, MN** (L6) **55024**

4. TYPE OF ACTION: **2** (L8)
1. Initial 2. Recertification
3. Termination 4. CHOW
5. Validation 6. Complaint
7. On-Site Visit 9. Other
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9) **09/29/2003**

6. DATE OF SURVEY **11/16/2017** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID	15 ASC	
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FISCAL YEAR ENDING DATE: (L35)
12/31

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To (b) :

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13.Total Certified Beds **65** (L17)

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A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC
X B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	65			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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17. SURVEYOR SIGNATURE Date :
Dawn Chiabotti, HFE NEII 12/28/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 01/11/2018 (L20)

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

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

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23. LTC AGREEMENT BEGINNING DATE
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25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
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04-Other Reason for Withdrawal
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05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

December 5, 2017

Ms. Elizabeth Letich, Administrator
Trinity Care Center
3410 213th Street West
Farmington, MN 55024

RE: Project Number S5250027

Dear Ms. Letich:

On November 16, 2017, a standard 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 a pattern of deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level E), as evidenced by the electronically delivered CMS-2567 whereby corrections are required.

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.

This letter provides important information regarding your response to these deficiencies and addresses the following issues:

Opportunity to Correct - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;

Electronic Plan of Correction - when a plan of correction will be due and the information to be contained in that document;

Remedies - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;

Potential Consequences - the consequences of not attaining substantial compliance 3 and 6 months after the survey date; and

Informal Dispute Resolution - your right to request an informal reconsideration to dispute the attached deficiencies.

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

DEPARTMENT CONTACT

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

Gloria Derfus, Unit Supervisor
Metro C Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: gloria.derfus@state.mn.us
Phone: (651) 201-3792
Fax: (651) 215-9697

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by December 26, 2017, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

ELECTRONIC PLAN OF CORRECTION (ePoC)

An ePoC for the deficiencies must be submitted within ten calendar days of your receipt of this letter. Your ePoC must:

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;

- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;

- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,

- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

The state agency may, in lieu of a 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:

- Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));

- Per day civil money penalty (42 CFR 488.430 through 488.444).

Failure to submit an acceptable ePoC could also result in the termination of your facility's Medicare and/or Medicaid agreement.

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC 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. 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, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. A Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.

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.

Original deficiencies not corrected

If your facility has not achieved substantial compliance, we will impose the remedies described above. If the level of noncompliance worsened to a point where a higher category of remedy may be imposed, we will recommend to the CMS Region V Office that those other remedies be imposed.

Original deficiencies not corrected and new deficiencies found during the revisit

If new deficiencies are identified at the time of the revisit, those deficiencies may be disputed through the informal dispute resolution process. However, the remedies specified in this letter will be imposed for original deficiencies not corrected. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed.

Original deficiencies corrected but new deficiencies found during the revisit

If new deficiencies are found at the revisit, the remedies specified in this letter will be imposed. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed. You will be provided the required notice before the imposition of a new remedy or informed if another date will be set for the imposition of these remedies.

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 February 16, 2018 (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). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was

issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by May 16, 2018 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. 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.

INFORMAL DISPUTE RESOLUTION

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: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_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 plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

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.

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:

Mr. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
445 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145
Email: tom.linhoff@state.mn.us
Telephone: (651) 430-3012
Fax: (651) 215-0525

Feel free to contact me if you have questions related to this letter.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: mark.meath@state.mn.us
Telephone: (651) 201-4118
Fax: (651) 215-9697
cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245250	A. BUILDING _____ B. WING _____	11/16/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRINITY CARE CENTER	**3410 213TH STREET WEST 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 000	INITIAL COMMENTS On November 13, 14, 15, and 16, 2017, a recertification survey was completed by surveyors from the Minnesota Department of Health (MDH) to determine compliance with requirements at 42 CFR Part 483, subpart B, requirements for Long Term Care Facilities. The facility's electronic Plan of Correction (ePoC) 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.	F 000		
F 323 SS=D	FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES CFR(s): 483.25(d)(1)(2)(n)(1)-(3) (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment	F 323		12/13/17

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

Electronically Signed | 12/14/2017

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245250	A. BUILDING _____ B. WING _____	11/16/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRINITY CARE CENTER	**3410 213TH STREET WEST 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 323	Continued From page 1 from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure assistive devices, side rails, were thoroughly assessed and safely applied for 1 of 5 residents (R89) reviewed for accidents. Findings include: R89's bilateral side rails, which were approximately 1/3 size rails, were observed in the up position on 11/14/17, at 11:31 a.m. The rail on the window side of the bed was noted to not fit the bed securely, and had a give of approximately 3 inches from the mattress outward. The rail on the door side of the bed had give of approximately two inches from the mattress outward. R89's Face Sheet indicated R89 had been admitted to the facility on 10/6/17 with diagnoses including: fracture of right tibia and generalized weakness. A progress note dated 10/6/17, indicated R89 had experienced a fall at home prior to admission to the facility. The admission Minimum Data Set dated 10/13/17, indicated R89's cognition was intact, but that R89 required staff assistance with bed mobility and transfers, and that the resident's balance was unsteady when moving from bed to chair. The	F 323	F323 Resident R89 1/3 mobility rails were removed on 11/15/17. Resident R89 received a new bed and new bilateral grab bars on 11/15/17. A comprehensive safety assessment of the grab bars was completed on 11/15/17. All other resident's utilizing 1/3 mobility rails were re-assessed and all 1/3 mobility rails were either removed as they were no longer needed or if mobility rails were needed, they were replaced with grab bars based upon the results of the assessment. The mobility rails policy and procedure was reviewed and revised to ensure assistive devices, side rails, were thoroughly assessed and safely applied for all residents. All Staff responsible for completing mobility rail assessments were re-educated on updated rails policy and procedure. DON or designee will complete random audits to ensure compliance 2x/week for 4 weeks, then 2x/month for 2 months and then monthly thereafter. Audits will ensure assistive devices, side rails, were thoroughly assessed and safely applied for all residents. Audit results will be reported to the QAPI committee and the QAPI	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245250	A. BUILDING _____ B. WING _____	11/16/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRINITY CARE CENTER	**3410 213TH STREET WEST 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 323	Continued From page 2 corresponding Care Area Assessment dated 10/13/17, also indicated R89 had physical weakness and was at risk for falls. During observations on 11/14/17, at 3:59 p.m. and 11/15/17 at 7:22 a.m., R89 was observed lying in bed with both side rails in the up position. On 11/15/17, at 2:06 p.m. R89 was observed in bed with the rail on the window side of the bed observed in the up position and the rail on the door side (exit side) in the down position. On 11/15/17, at 8:27 a.m. the assistant director of nursing (DON) stated the nurse managers were responsible for completing side rail assessments. On 11/15/17, at 1:46 p.m. registered nurse (RN)-B stated R89 had been admitted to the facility on 10/6/17 and that she (RN-B) had completed the resident's side rail assessment on 10/10/17. RN-B stated R89 needed staff assistance with transfers and that R89 was working with therapy. RN-B stated nurses assessed for safety with the side rails and therapy assessed whether residents utilized side rails. RN-B stated the nurse would physically check the side rails to ensure they were "snug, secure." RN-B acknowledged a side rail assessment should be completed the day they were initiated. On 11/15/17, at 2:10 p.m. RN-B observed the siderails with surveyor and verified the bilateral side rails had give from the bed mattress outward. RN-B stated since the side rails were loose and required tightening, she would follow up with maintenance. On 11/15/17, at 2:16 p.m. the nursing assistant	F 323	committee will recommend the need for ongoing monitoring. Completion Date: 12/13/17	

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	245250	A. BUILDING _____ B. WING _____	11/16/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 323	Continued From page 3 (NA)-B stated maintenance slips were kept in an orange binder at the nurse's station. NA-B said staff were supposed to fill out repair/maintenance need slips and put them in the box as needed. NA-B verified there were no maintenance slips in the box to indicate R89's side rails required attention. NA-B also stated R89 sometimes grabbed onto his side rail when getting out of bed to stand up while putting the other hand on his walker. Review of the undated Aide Assignment Sheet for R89 indicated R89 required assistance of one staff for transfers with the walker. R89's care plan dated 10/6/17, indicated R89 was to have staff assistance for bed mobility as needed and may need assistance with getting legs in and out of bed. The Side Rail Assessment completed by RN-B, dated 10/10/17, indicated R89 was alert and oriented with intermittent confusion. The assessment also indicated R89 used the side rails for turning side to side, moving up and down in bed, and for safety when exiting the bed. The assessment did not address the security and/or looseness of the side rails. On 11/15/17, at 2:05 p.m. the facility's nurse consultant (NC) stated the facility had identified issues with some side rails in the facility needing replacement during a mock survey held a month or two ago. The NC stated as a result of the mock survey findings, they were planning on replacing some of the side rails. When the surveyor asked when the side rails would be replaced, the NC stated she did not know.	F 323		

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F 323	Continued From page 4 On 11/16/17, at 9:52 a.m. the director of nursing (DON) stated when a resident was admitted to the facility, the nursing staff were to complete a safety assessment initially, which she said was usually done on the day of admission. The DON stated they did not routinely remove side rails or grab bars from the beds between residents, so the side rails and grab bars stayed with the bed. The DON stated the admitting nurses had been using a consent form with risks/benefits to assess for safety, but the complete nursing side rail assessment would be completed later by the nurse managers who would include a therapy mobility assessment. The facility's Mobility Rail Policy, dated 9/21/16 included: "...will ensure that a resident with bed side rail placement on his or her bed has an individual assessment to determine safety based upon the resident needs as consistent with state and federal rules and regulations. Procedure: To ensure a safe and comfortable environment for each resident with side rails as consistent with state and federal regulations..."	F 323		
F 431 SS=E	DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS CFR(s): 483.45(b)(2)(3)(g)(h) The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. (a) Procedures. A facility must provide pharmaceutical services (including procedures	F 431		12/13/17

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F 431	Continued From page 5 that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. (b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-- (2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and (3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. (g) Labeling of Drugs and Biologicals. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. (h) Storage of Drugs and Biologicals. (1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. (2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the	F 431		

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F 431	Continued From page 6 quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure medications were no longer available for use after outdates, and failed to ensure medications were stored at proper temperatures, for 9 of 10 residents (R24, R82, R69, R2, R89, R16, R45, R19, R5) reviewed for medication storage. Findings include: Cottages: Outdated medications: The Cottages medication cart was observed with registered nurse (RN)-C on 11/13/17, at 2:19 p.m. R24 had a bottle of latanoprost (Xalatan-used to treat glaucoma) eye drops opened and in the cart. The bottle was an 1/8 full and dated opened on 9/12/17. The label on the bottle indicated R24 received one drop in each eye at bedtime. RN-C verified there was no other bottle of the eye drops available for use in the medication cart for R24. RN-C verified, the facility's undated guideline from the pharmacy, indicated once the Latanoprost eye drops had been opened, they were only good for 42 days. RN-C stated R24's Latanoprost had been open for use for 42 days as of 10/24/17, so they were currently outdated and should be disposed of. On 11/13/17, at 2:42 p.m. the licensed practical nurse (LPN)-A stated she had given R24's eye drops last evening from the outdated bottle of Latanoprost. R24's Face Sheet printed out 11/16/17, indicated	F 431	F431 On 11/13/17 all medications for R24, R82, R69, R2, R89, R16, R45, R19, and R5 were removed and replaced. On 11/13/17 an updated fridge temp log was placed on the refrigerators in both the cottages and the crossroads medication refrigerators. Education was completed for all licensed nursing staff and TMA's on 11/13/17 through 11/17/17 regarding policy and procedure for refrigerator temperatures and expired medications. The facility has purchased a new refrigerator to store all medications in to assist with temperature regulation. DON or designee will conduct random audits of refrigerator temps and med cart review for expired medications 2x/week for 4 weeks, then 2x/month for 2 months and then monthly thereafter. Audit results will be reported to the QAPI committee and the QAPI committee will recommend the need for ongoing monitoring. Completion Date: 12/13/17	

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F 431	Continued From page 7 R24 admitted to the facility on 7/12/17. Physician Orders dated 7/13/17, included an order for Latanoprost one drop in both eyes every day. Refrigerated medications: The Cottages medication refrigerator was observed with RN-C on 11/13/17, at 2:19 p.m. RN-C verified refrigerator thermometer read 28 degrees Fahrenheit. RN-C stated the night nurse checked the temperature of the refrigerator. RN-C stated she would contact her manager about the refrigerator being too cold. Other medications in the medication refrigerator at time of observation were: - Four boxes of stock Tylenol (a mild analgesic) 650 mg (milligrams) suppositories, - Three boxes of stock glycerin suppositories (used for constipation), - An unopened bottle of Latanoprost eye drops for R24 inside a plastic bag with a green label from pharmacy "refrigerate", and - Two bottles of Latanoprost for R82, both unopened, one dated pharmacy label 9/5/17, and one 9/23/17. The November 2017 temperature log (on door of medication refrigerator) for Cottages indicated temperature on 11/9/17, was at 30 degrees. On 11/13/17, at 6:10 p.m. RN-E verified the medication refrigerator in Cottages was 34 degrees Fahrenheit and adjusted the dial to "get warmer" and stated she would come back in an hour and recheck. Crossroads: Expired medication:	F 431		

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F 431	Continued From page 8 On 11/13/17, at 5:27 p.m. RN-E verified the emergency kit with expired medications Novolog vial expiration 10/2017, two vials of Ativan expired 11/1/17 Refrigerated medication: On 11/13/17, at 5:27 p.m. RN-E verified the temperature in the Crossroads medication refrigerator was 32-34 degrees, out of range from the 36-40 degrees as listed on the temperature log on the outside of the medication refrigerator. RN-E adjusted the dial stating, "so the refrigerator would get a little warmer" and would recheck in an hour to see if was within range. RN-E verified on the November 2017 log on outside of the refrigerator the temperature noted each night was out of range and too cold for 10 of the 12 days marked on the log. RN-E stated nurses on the evening and night shift checked the refrigerator temperature during influenza season but verified on the November 2017 log on the refrigerator that only night nurses had been documenting temperatures. The November 2017 temperature log (on door of medication refrigerator) for Crossroads indicated temperatures of: - 11/1 34 degrees - 11/2 34 degrees - 11/3 34 degrees - 11/4 32 degrees - 11/5 31 degrees - 11/6 34 degrees - 11/8 32 degrees - 11/9 32 degrees - 11/10 32 degrees - 11/11 34 degrees RN-E verified the medications in the Crossroads	F 431		

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F 431	Continued From page 9 medication refrigerator on 11/13/17, at 5:27 p.m. included: - R24's bottle of eye drops Xalatan pharmacy label dated 11/6/17, unopened, - R82's bottle of Xalatan eye drops unopened pharmacy label 9/23/17, R82's bottle of Xalatan unopened pharmacy date 9/5/17, - R69's vial of unopened Lantus (used blood sugar control) pharmacy date 11/9/17, - One box of house stock Tylenol suppositories and bag of 20 individual Tylenol suppositories, - R2's box of Tylenol 650 mg suppositories pharmacy date 11/6/17, R2's bottle of Ativan (used for anxiety) opened 3/4 full, pharmacy label date 11/6/17, R2's bottle unopened Ativan pharmacy label 11/10/17, - Seven boxes of influenza multi dose vials, one opened dated 10/17/17, - One opened vial of TB dated 11/10/17, two unopened multi dose TB vials, - R89's bottle of unopened Latanoprost pharmacy date 10/20/17, R89's vial of Lantus unopened pharmacy label date 11/4/17, R89's vial of Novolog (used to control blood sugar) unopened pharmacy label date 10/8/17, - R16's Prevnar 13 (vaccine used to prevent infection caused by pneumococcal bacteria) unopened pharmacy label date 9/20/17, - R45's syringe Prevnar 13 unopened pharmacy date 6/29/17, - R19's 3 Lantus pens unopened pharmacy label date 10/31/7, and one Humalog pen unopened pharmacy label date 10/22/17, indicated on it "refrig [refrigerator] prior to use do not freeze", and - R5 a vial of Lantus for unopened pharmacy label date 10/8/17. On 11/13/17, at 7:32 p.m. RN-E verified the	F 431		

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F 431	Continued From page 10 Crossroads medication refrigerator was 44 degrees, took out the medications to dispose and said the director of nursing (DON) was going to reorder new medications. On 11/16/17, at 10:12 a.m. DON stated nurses should be checking medications for shortened time frames and expiration datelines and stated a guideline sheet from Thrifty Drug was located at both nursing stations. DON stated nurses should notify supervisor when refrigerator is not within guidelines and stated the temperature should be within 36-46 degrees and not 36-40 degrees the logs indicated. DON stated temperatures were to be checked twice a day on evenings and nights and stated unfortunately an old form had been put out for November so then only nights had documented. DON stated she had disposed of the medications that were in the refrigerators and reordered new medications. DON stated she knew the refrigerators and thermometers were good and that the medications had just gotten too cold so needed to be disposed and reordered. The facility's Medication Storage Policy dated 9/27/16, Medication Storage Policy indicated, "The facility shall store all drugs and biologicals in a safe, secure, and orderly manner." In addition the policy read "4. The facility shall not use discontinued, outdated, or deteriorated drugs or biologicals. All such drugs shall be returned to the dispensing pharmacy or destroyed." The policy also indicated "Medication refrigerator temperatures are to be kept between 36-46 degrees Fahrenheit." and "during flu season, temps will be taken twice a day in the refrigerators where they are stored." The United States National Library of Medication	F 431		

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F 431	Continued From page 11	F 431		

package insert for Tylenol suppositories dated 1/12/12, directed the user to store the medication at 8-25 degrees C (46-77 F).

The Sandoz Inc., package insert for Latanoprost eye drops dated 7/12, directed the user to store the unopened medication under refrigeration at 2° to 8°C (36° to 46°F). In addition, the manufacturer indicated once a bottle was opened for use, it would be stored at room temperature up to 25°C (77°F) for six weeks.

The Dispensing Solutions package insert for Lantus dated 9/20/11, directed the user to store in a refrigerator (not the freezer) between 36°F to 46°F.

The Major Pharmaceuticals package insert for Ativan dated 5/30/17, directed the user to store at 20° to 25°C (68° to 77°F).

The Seqirus package insert for the flu vaccine dated 3/14/17, directed the user to store at 2-8°C (36-46°F).

The A-S Medication Solutions Novolog package insert dated 12/7/16, directed the user to store unopened Novolog vials in the refrigerator at 36 degrees F to 46 degrees F (2- C to 8- C).

The Pfizer package insert for Prevnar 13 dated 7/16, directed the user store refrigerated at 2ºC to 8ºC (36ºF to 46ºF).

The Dispensing Solutions package insert for Humalog dated 9/27/12, directed the user to store in a refrigerator at 36°F to 46°F (2°C to 8°C).

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	245250	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**11/14/2017**

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K 000	INITIAL COMMENTS 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 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ON-SITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety - State Fire Marshal Division. At the time of this survey, (Name of facility) 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) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St Paul, MN 55101-5145, or By email to: Marian.Whitney@state.mn.us and	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		12/14/2017

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K 000	Continued From page 1 Angela.Kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Trinity Care Center is a 1-story building with partial basement under the 2007 addition. The building was constructed at 4 different times. The original building was constructed in 1967 and was determined to be of Type II(222) construction. In 1972, addition was constructed to the South Wing that was determined to be of Type II(222) construction. In 1995, another addition was constructed to the West Wing that was determined to be of Type II (111) construction. The 2008 addition is a 1-story building with a partial basement. and was determined to be of Type II(222) construction. Because the original building and the additions are of the same type of construction and meet the construction type allowed for existing buildings, the facility was surveyed as one building. The building is fully sprinklered. The facility has a fire alarm system with full corridor smoke detection and spaces open to the corridors that is monitored for automatic fire department notification.	K 000		

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K 000	Continued From page 2 The facility has a capacity of 65 beds and had a census of 57 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 374 SS=E	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9 This REQUIREMENT is not met as evidenced by: Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal	K 374	K374 On 11/14/17 Environmental Services Director (ESD) corrected the failed latch of the smoke barrier doors in the therapy room and smoke barrier doors in the cottage wing. ESD or designee will conduct random audits of the smoke barrier doors to ensure the safety of all residents, staff and visitors within the smoke compartment. Audits will be completed 2x/week for 4 weeks, then 2x/month for 2 months and monthly thereafter. Audit results will be reported to	11/14/17

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 _____	**11/14/2017**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRINITY CARE CENTER	**3410 213TH STREET WEST** **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 374	Continued From page 3 doors. 19.3.7.6, 19.3.7.8, 19.3.7.9 Findings Include: On facility tour between 10:00 AM and 02:00 PM on 11/14/2017, based on observation and interview revealed that the following include: 1. Observation during the inspection found smoke barrier doors in the therapy room does not latch closed when tested. 2. Observation during the inspection found smoke barrier doors in the cottage wing does not latch closed when tested. This deficient practice could affect the safety of all the residents, staff and visitors within the smoke compartments. This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery	K 374	the QAPI committee and the QAPI committee will recommend the need for ongoing monitoring.	