STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 355074	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Trinity Homes	305 8th Ave NE Minot, ND 58703

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 355074	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/19/2025

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, review of the facility reported incident (FRI) and investigation, review of competency/verification/training documents, and staff interview, the facility failed to provide supervision and assistance devices to prevent an accident for 1 of 1 sampled resident (Resident #1) injured during a facility van transport. Failure to secure the shoulder strap on the resident during transport resulted in Resident #1 sustaining a leg fracture. This citation is considered past non-compliance based on review of the corrective actions the facility implemented immediately following the incident. Findings include:The surveyor determined a deficient practice existed 11/17/25. The facility implemented corrective action on 11/18/25. Review of the initial FRI report, dated 11/17/25 at 2:00 p.m. stated, Resident was being transported back to facility. Resident fell out of wheelchair when stopping at a stoplight. Resident was sent to ER [emergency room] due to pain in lower extremity.During an interview on 11/19/25 at 9:45 a.m., an administrative staff member (#2) stated Resident #1 was admitted to the hospital on [DATE] and had surgery on 11/18/25 to repair a fractured femur (upper thigh bone).Review of Resident #1's medical record occurred on 11/19/25. A progress note, dated 11/17/25 at 2:00 p.m. stated, Resident was in the van on the way from an appointment. He had been leaning forward in the wheelchair. At a stoplight, he fell out of his wheelchair. Resident stated a vehicle in front of them slammed on the brakes so the transporter had to slam on the brakes. The resident then fell out of his wheelchair. A resident assist was called upon return to facility. Resident has an abrasion to his right knee with some light bruising and swelling. He also complains of shooting pain from his knee to his hip. NP [nurse practitioner] notified with order to send to ER for evaluation and treat.Review of the facility's investigation of the incident identified the driver of the van (Transporter #7) didn't realize he/she had not placed the shoulder strap seatbelt on the resident in the van until he heard the resident fall. The report stated when the transporter was securing the wheelchair to the floor of the van, both the transporter and the resident were visiting and forgot to secure the seatbelt that crosses over the resident. During the facility's interview with Resident #1, the resident confirmed that he and the transporter were talking and he was distracted by their conversation. During an interview on the morning of 11/19/25, an administrative nursing staff member (#3) stated there are three employees who transport residents in the van, and provided documentation that all three employees had completed a Competency Verification/Training Checklist - Van Driver prior to becoming transporters. During an interview on the afternoon of 11/19/25, an administrative staff member (#2) stated as part of the investigation he/she interviewed other alert residents who had been transported in the van during the month of November 2025. The staff member confirmed all the residents interviewed stated they have been secured by the crossover belt by the drivers (including Transporter #7) when transported in the van and they felt safe. One of the residents interviewed rode in the van the morning of 11/17/25 and stated the driver (Transporter #7) secured the shoulder strap seatbelt.The facility failed to ensure the shoulder strap seatbelt was secured on Resident #1 while being transported in the van and resulted in a fracture. Based on the following information, non-compliance is considered past non-compliance. The facility implemented corrective actions for other residents who may be affected by the deficient practice as follows:* Immediately suspended the van driver until investigation completed.* Immediately suspended all resident van transportation until education provided to staff.* Completed investigation of Resident #1's incident and injury.* Implemented a Wheelchair Van Checklist to be used every pre-departure.* Provided education to the van drivers on 11/18/25 and will continue education for transporter/van driver (#7) prior to return to work. * Implemented quality assurance audits on each van driver to ensure safety checklist is used to secure resident in the van or bus.