STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255222	A. BUILDING _____ B. WING _____	C 05/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRINITY HEALTHCARE CENTER	230 AIRLINE ROAD COLUMBUS, MS 39702

(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 The State Agency (SA) conducted an annual re-certification survey along with a complaint investigation (CI) MS #25191 at the facility from 5/28/24 through 5/30/24. During the survey, the SA determined that the facility was not in compliance with Medicare and Medicaid requirements of participation related to F623, F656, F677, F697, F761 and F880. The facility was found to be in compliance with CI MS #25191 and cited F602 at Past Non-Compliance for failure to prevent misappropriation of a residents property. The census at the time of the survey was 58 with a bed capacity of 60.	F 000		
F 602 SS=D	Free from Misappropriation/Exploitation CFR(s): 483.12 §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on staff interview, record review, and facility policy review, the facility failed to ensure that a resident's personal property was safeguarded, and that staff did not misappropriate property for one (1) of 56 residents residing in the facility. Resident #23. Based on actions taken by the facility on 5/23/24, this was determined to be Past Non-Compliance.	F 602	Past noncompliance: no plan of correction required.	

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

Electronically Signed | 06/12/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255222	A. BUILDING _____ B. WING _____	C 05/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRINITY HEALTHCARE CENTER	230 AIRLINE ROAD COLUMBUS, MS 39702

(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 602	Continued From page 1	F 602		

Findings include:

Review of the facility policy titled "Abuse, Neglect, and Exploitation" with a revision date of 3/15/204 revealed under, "Policy: It is the policy of this facility to provide protections for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation and misappropriation of resident property..."

Record review of the internal investigation conducted by the Administrator (ADM) dated 5/22/2024 for Resident #23 revealed, "On May 21, 2024, at 3:30 PM, Director of Nursing (DON) reported to me that she suspected Certified Nurse Assistant (CNA) #1, had taken a bottle of lotion from an elder (Resident). The DON reported that today around 2:55 PM, CNA #1 was in her office. She was speaking with her, and "proper name of employee" and picked up a pair of jogging pants out of a bag in the office to show them something. The DON happened to notice a bottle of lotion in the bag that was the same kind she had purchased and put into a gift basket for two of our elders for their birthday on Sunday. The DON went on to say that CNA #1 made the comment that the bag was hers ... At this time, CNA #1 picked up the bag and exited the building towards the parking lot. The DON reported that she then went to the rooms of the elder that she had made birthday baskets for on Sunday and noticed that she did not see the lotion in the basket she had given Elder #23 ... Upon review of camera footage, CNA #1 was seen at 2:40 PM exiting Elder #23's room and placing the bottle of lotion into the right leg scrub pocket of her

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255222	A. BUILDING _____ B. WING _____	C 05/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRINITY HEALTHCARE CENTER	230 AIRLINE ROAD COLUMBUS, MS 39702

(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 602	Continued From page 2	F 602		

scrubs. This is a large bottle of lotion, and the top portion of the bottle can be seen in the pocket as CNA #1 walks up the hall and enters the DON's office at 2:41 PM. Abuse by means of misappropriation can be substantiated related to this incident..."

An observation of Resident #23 on 5/28/2024 at 10:26 AM, revealed she was alert to name only.

An interview with Resident #23's daughter on 5/28/2024 at 2:32 PM, revealed her mother was not cognizant and would not be aware of any missing personal items. She explained that the facility called and notified her sister about the missing bottle of lotion after it happened. She revealed they did not buy the lotion; it came in a gift basket the facility provided for her mother's birthday. The daughter stated both she and her sister came to the facility and looked through her mother's personal items, but were unable to find the lotion.

On 5/29/2024 at 2:20 PM, review of the camera footage captured on 5/21/2024 at 2:38 PM revealed, CNA #1 entered Resident #23's room with no lotion visible in her pant pockets and later exits the room while placing a white bottle into her right scrub pant pocket. She was then seen walking down the hallway with the upper portion of the white bottle visible in her right pocket, and entered an office.

An interview with the DON on 5/29/2024 at 2:40 PM, revealed CNA #1 had a bag in her office the day of the incident because she had bought her a jogging suit. The DON explained that she observed a bottle of lotion in CNA #1's bag that looked identical to the bottle that she had

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255222	A. BUILDING _____ B. WING _____	C 05/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRINITY HEALTHCARE CENTER	230 AIRLINE ROAD COLUMBUS, MS 39702

(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 602	Continued From page 3	F 602		

purchased and given out to Elder #23 in a gift basket over the weekend. She revealed after CNA #1 picked up the bag and left for the day, she went down to Elder #23's room and was unable to locate the lotion in the gift basket. She revealed she spoke with the Administrator (ADM) and notified her. The DON explained that they reviewed the camera footage, which confirmed that CNA #1 went into the resident's room and came out with the lotion bottle and placed it in her pocket. She revealed they called and notified CNA #1 that she was suspended pending the investigation. The DON revealed CNA #1 denied the allegation and revealed that she had brought the lotion to work with her to use on the Elders.

An interview with the ADM on 5/29/2024 at 3:26 PM, confirmed through investigation of the camera footage and witness statements the misappropriation of Resident #23's property was substantiated and CNA #1 was terminated.

A telephone interview with CNA #1 on 5/30/2024 at 10:32 AM, revealed she was called by the ADM and told that she was caught on a camera recording taking some lotion out of Resident #23's room. She revealed that she did not take the lotion and explained that she brought her lotion to work to use because she had sensitive skin. CNA #1 stated she kept her lotion in her pocket all day, which was what the camera caught.

The SA validated through record review that an in-service was conducted on Abuse/Neglect on 5/21/24 with all staff with sign in sheets.

The SA validated through interview with the Administrator and record review of the facility

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255222	A. BUILDING _____ B. WING _____	C 05/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRINITY HEALTHCARE CENTER	230 AIRLINE ROAD COLUMBUS, MS 39702

(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 602	Continued From page 4 investigation that an investigation was conducted, CNA #1 was suspended and terminated on 5/23/24. The SA determined this to be Past Non-Compliance. Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 3/13/2024 revealed, under section C, a Brief Interview for Mental Status (BIMS) summary score of 6, which indicated that Resident #23 is severely cognitively impaired. Record review of the "Admission Record" revealed the facility admitted Resident #23 on 6/21/2022 with a medical diagnosis of unspecified dementia.	F 602		
F 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and	F 623		6/19/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255222	A. BUILDING _____ B. WING _____	C 05/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRINITY HEALTHCARE CENTER	230 AIRLINE ROAD COLUMBUS, MS 39702

(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 623	Continued From page 5	F 623		

(c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged.
(ii) Notice must be made as soon as practicable before transfer or discharge when-
(A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section;
(B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;
(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;
(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or
(E) A resident has not resided in the facility for 30 days.

§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:
(i) The reason for transfer or discharge;
(ii) The effective date of transfer or discharge;
(iii) The location to which the resident is transferred or discharged;
(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;
(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255222	A. BUILDING _____ B. WING _____	C 05/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRINITY HEALTHCARE CENTER	230 AIRLINE ROAD COLUMBUS, MS 39702

(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 623	Continued From page 6 (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on staff interview, record review and facility policy review, the facility failed to send a written notice to the resident representative	F 623	1. Time for correction has passed for Resident #8 due to transfer being on January 21, 2024. Licensed Social	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255222	A. BUILDING _____ B. WING _____	C 05/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRINITY HEALTHCARE CENTER	230 AIRLINE ROAD COLUMBUS, MS 39702

(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 623	Continued From page 7 regarding a resident being transferred to the hospital for one (1) of three (3) residents reviewed for hospitalizations. Resident #8 Findings Include: Review of the facility policy titled, "Transfer and Discharge" dated 10/2022, revealed under, "Policy Explanation and Compliance Guidelines ...#4. The facility's transfer/discharge notice will be provided to the resident and the resident's representative in a language and manner in which they can understand..." Record review of Resident #8's hospital discharge summary dated 1/21/24 revealed the resident was hospitalized for a possible head injury due to a fall. An interview on 5/29/24 at 11:05 AM, with the Licensed Practical Nurse (LPN)/Medical Records revealed she does not mail a transfer/discharge notice to the resident representative when the resident is discharged. She stated that there is a form in the facilities electronic record system that they complete and send with the resident when they go to the hospital, but that form is not mailed or saved, and the computer system deletes it after 30 days. She admitted that she was not aware of the regulation to send a written notice when a resident is transferred or discharged. An interview on 5/29/24 at 4:40 PM, with the Administrator confirmed the facility was not sending written notices to the representative for transfer/discharges and was unaware of the regulation to do so and stated they would work on developing something and get started doing that.	F 623	Worker/Discharge Planner was educated, by Administrator, on Discharge/ Transfer/ Bed Hold requirement on 5/30/2024. 2. All residents transferred have the potential to be affected by the deficient practice. 3. On 6/3/2024 Licensed Practical Nurse (LPN) Medical Records and Licensed Social Worker (LSW) were educated on Discharge/Transfer/ Bed Hold Policy by Administrator. On 5/30/2024 Discharge/ Transfer/ Bed Hold form was updated to include location, date, time, and reason for transfer. Going forward Discharge/ Transfer/ Bed Hold form will be electronically sent or mailed to representative, and hand delivered to resident then documented in the medical record by LSW. 4. Administrator will audit Discharge/Transfer/Bed Hold notices weekly for four weeks then monthly for two months beginning on 5/30/2024. Results from these audits will be brought and reviewed with Quality Assurance and Performance Improvement Plan Committee starting on 6/19/2024 and thereafter, for at least three months, until consistent substantial compliance has been achieved as determined by the committee.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255222	A. BUILDING _____ B. WING _____	C 05/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRINITY HEALTHCARE CENTER	230 AIRLINE ROAD COLUMBUS, MS 39702

(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 623	Continued From page 8 Review of Resident #8's "Admission Record" revealed the resident was admitted to the facility on 5/13/23 with medical diagnoses that included Unspecified Dementia, mild with other behavioral disturbances.	F 623		
F 656 SS=G	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes.	F 656		6/19/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255222	A. BUILDING _____ B. WING _____	C 05/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRINITY HEALTHCARE CENTER	230 AIRLINE ROAD COLUMBUS, MS 39702

(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 656	Continued From page 9 (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, record review and facility policy review, the facility failed to implement a comprehensive care plan for a resident exhibiting nonverbal signs of pain and a care plan to address ADL (activities of daily living) of a resident for two (2) of 19 resident care plans reviewed. Resident #29 and Resident #17. Findings Include: Review of the facility policy titled, "Comprehensive Care Plans" with no revision date revealed it is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment. Resident #29	F 656	1. Resident #29's care plan was reviewed and updated to remove goal of verbalizing pain reduction or relief to "will not have any signs or symptoms of non-verbal pain. On 5/29/2024 Resident # 17 was asked his shaving preference by Minimum Data Set Coordinator (MDS) #2. On 5/29/2024 Resident # 17 was shaven to his preference by Certified Nursing Assistant (CNA) #1, at the request of the Director of Nursing (DON). Resident # 17's care plan was reviewed and updated to reflect his preference to be shaven daily on 5/29/2024 by MDS coordinator #1. 2. The Interdisciplinary Team (IDT) determines that all elders have the potential to be affected by the deficient practice. 3. All IDT care plan team members responsible for writing care plans were educated on the facility's policy and procedure for developing comprehensive care plans by the Director of Nursing	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255222	A. BUILDING _____ B. WING _____	C 05/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRINITY HEALTHCARE CENTER	230 AIRLINE ROAD COLUMBUS, MS 39702

(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 656	Continued From page 10 Record review of Resident #29's care plans revealed a care plan regarding Elder is at risk for pain with a goal of; The elder will verbalize pain reduction or relief with each intervention. Interventions included administer pain medications as ordered and monitor for effectiveness, observe for need for pain medications prior to any care and observe for verbal/nonverbal indications of discomfort. An observation on 05/28/24 at 11:03 AM revealed that two staff members were leaving Resident #29's room with a bag of garbage and the resident was moaning loud enough to be heard in the hallway. Upon entry into the resident's room, the resident was sitting up in her wheelchair, dressed in personal clothes and continued making loud moaning noises with her mouth open at all times, her eyebrows were furrowed, and a single tear fell from her right eye. The resident was unable to be interviewed and could not answer questions at this time. An interview on 5/28/24 at 11:20 AM with Licensed Practical Nurse (LPN) #2 revealed the aides were getting Resident #29 up out of bed when they were observed leaving the room around 11:00 AM. During an interview on 5/29/24 at 10:45 AM, with Certified Nurse Assistant (CNA) #2 confirmed that Resident #29 moans most of the time, but when they get her up or move her, she moans loader. She stated that the resident's care plans are to let the staff know what care the resident needs and we should have let her nurse know she was moaning out and they could give her pain medication.	F 656	(DON) on 6/11/2024. All licensed nursing staff will be educated, by the Director of Nursing, on following care plans and reporting signs and symptoms of pain by 6/14/2024. As of 6/10/2024 all Care plans were updated, and a task was added to each resident's Point of Care, per their preference, for instructions and for documentation of shaving assistance to be provided. 4. Beginning on 5/30/2024 Comprehensive Care Plans will be reviewed weekly in accordance with the care plan review schedule by the MDS Coordinators. All comprehensive care plans will be updated in accordance with their MDS assessment. Beginning on 5/30/2024 the DON or Quality Assurance (QA) nurse will perform audits of 3 Comprehensive care plans weekly for four weeks then monthly for two months. The observation results will be reviewed by the Quality Assurance and Performance Improvement Plan Committee on 6/19/2024 and thereafter, for at least 3 months, until consistent substantial compliance has been achieved as determined by the committee.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255222	A. BUILDING _____ B. WING _____	C 05/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRINITY HEALTHCARE CENTER	230 AIRLINE ROAD COLUMBUS, MS 39702

(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 656	Continued From page 11	F 656		

During an interview on 5/29/24 at 12:00 PM with Registered Nurse (RN)/Minimum Data Set (MDS) Nurse confirmed that Resident #29 had a diagnosis of Multiple Myeloma and movement probably increases the resident's pain. She stated that the only way to know for sure that the resident is in pain is if her moaning increased, but there would be no way to tell what the pain level was on a scale of 1-10, because the resident is unable to verbalize that information. She revealed that the residents care plan provides the care needed for the residents. She confirmed that she put in the resident's pain care plan and the care plan goal of the resident verbalizing pain relief would be difficult to for her to achieve.

On 5/29/24 at 3:30 PM, an interview with the Director of Nurses (DON) confirmed that it would be impossible for Resident #29 to give them a pain scale of 1-10 or let them know if she is relieved from the pain medication. She confirmed that the care plan needed some changing to apply more to this resident and was not being implemented to the best of its ability due to not providing as needed (PRN) pain medication or offering every 4 hours as ordered.

Record review of Resident #29's "Admission Record" revealed the resident was admitted to the facility on 3/11/24 with medical diagnosis that included Multiple Myeloma not having achieved remission and Secondary Malignant Neoplasm of Bone.

Record review of Resident #29's physicians orders revealed an order dated 3/15/24 for Hydrocodone-Acetaminophen tablet 5-325 milligrams (mg) by (via) PEG (Percutaneous Endoscopic Gastrostomy Tube) every 4 hours as

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255222	A. BUILDING _____ B. WING _____	C 05/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRINITY HEALTHCARE CENTER	230 AIRLINE ROAD COLUMBUS, MS 39702

(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 656	Continued From page 12	F 656		

needed for pain.

Record review of Resident #29's Electronic Medication Administration Record (EMAR) revealed the resident has received nine (9) PRN (as needed) Hydrocodone pills in the last 29 days with the last administration being 5/27/24 at 1:47 AM.

Resident #17

Record review of the ADL care plan for Resident #17 revealed the resident had an ADL self-care performance deficit related to activity intolerance, dementia, impaired balance, and stroke. Interventions included the resident requires substantial assistance by two (2) staff with personal hygiene.

On 5/28/2024 at 11:06 AM, an observation revealed Resident #17 sitting in a wheelchair in the day room with one-fourth (1/4) inch of gray facial hair observed to the sides of his face and above his lip.

On 5/29/2024 at 1:44 PM, an observation and interview with the Director of Nursing (DON) confirmed Resident #17 had long facial hair.

An interview with the Director of Nursing (DON) on 5/30/2024 at 10:25 AM revealed the purpose of the care plan was to have a guide to follow for resident care and confirmed the care plan for personal hygiene was not followed.

Record review of the "Admission Record" revealed the facility admitted Resident #17 on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255222	A. BUILDING _____ B. WING _____	C 05/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRINITY HEALTHCARE CENTER	230 AIRLINE ROAD COLUMBUS, MS 39702

(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 656	Continued From page 13 11/14/2023 with a medical diagnosis of unspecified dementia.	F 656		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interview, record review, and facility policy review, the facility failed to provide assistance with activities of daily living (ADLs) for a resident dependent on staff for shaving for one (1) of sixteen sampled residents. Resident #17 Findings Include: Record review of the facility policy titled "Grooming a Resident's Facial Hair" undated, revealed under, "Policy: It is the practice of this facility to assist residents with grooming facial hair to meet their preference." An observation of Resident #17, on 5/28/2024 at 11:06 AM, revealed he was sitting in a wheelchair in the day room. Gray facial hair observed on the sides of his face and above his lip, measuring approximately one-fourth (1/4) inch in length. An interview with Certified Nurse Aide (CNA) #2 on 5/29/2024 at 10:50 AM, revealed Resident #17 gets a shower on Tuesday, Thursday, and Saturday during the 3-11 shift. She confirmed the resident was unshaven, and reveled the resident should have been shaved yesterday, which would	F 677	1. Resident # 17 was interviewed by Minimum Data Set Coordinator # 2 on 5/29/2024 to determine his preference for shaving. On 5/29/2024, Resident # 17 was shaven, according to his preference, by Certified Nursing Assistant (CNA) # 1 at the request of the Director of Nursing (DON). Resident # 17's care plan was updated to reflect his desire to be shaven daily on 5/30/2024. A task with instructions for shaving resident # 17 was added to Point of Care for documenting shaving on the schedule that reflected Resident # 17's preference. 2. The Interdisciplinary Team (IDT) determined that all male residents were at risk for the deficient practice. 3. An audit of all male elders was completed by the Director of Nursing (DON) for facial hair on 5/29/2024. All male residents were interviewed by the Minimum Data Set Coordinator # 2 on 5/30/2024 to determine their shaving preference. Care plans were updated, and a task was added to each resident's Point of Care, according to their preference, for instructions and for documentation of	6/19/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255222	A. BUILDING _____ B. WING _____	C 05/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRINITY HEALTHCARE CENTER	230 AIRLINE ROAD COLUMBUS, MS 39702

(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 677	Continued From page 14 have been his scheduled shower day. An interview with Resident #17 on 5/29/2024 at 1:38 PM, revealed he preferred to be clean-shaven and voiced that he wanted to be shaved every other day. An observation and interview with the Director of Nursing (DON) on 5/29/2024 at 1:44 PM, confirmed Resident #17 had long facial hair. She revealed her expectation was for the aides to shave the male residents on their shower days. Record review of the "Admission Record" revealed the facility admitted Resident #17 on 11/14/2023 with a medical diagnosis of unspecified dementia.	F 677	shaving assistance to be provided. Beginning on 6/10/2024, all shaving preference will be asked on admission and residents that are dependent on assistance with shaving will have a task added, by the MDS coordinator(s), instructing staff on when to assist resident with shaving according to their preference. 4. Beginning on 5/30/2024, DON, Medical Records Licensed Practical Nurse (LPN) or Quality Assurance (QA) nurse will audit all male residents three times a week for four weeks then once a week for two months. Observation results will be reviewed by the Quality Assurance and Performance Improvement Plan Committee on 6/19/2024 and thereafter, for at least 3 months, until consistent substantial compliance has been achieved as determined by the committee.	
F 697 SS=G	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observations, staff and resident representative interviews, record review and facility policy review, the facility failed to ensure a resident was free from pain after exhibiting nonverbal signs of excruciating pain for one (1) or	F 697	1. Resident # 29 was assessed by the Nurse Practitioner on 5/29/2024 at 9:00 and an as needed pain medication was administered. On 5/29/2024 an order was obtained for routine pain medication for	6/19/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255222	A. BUILDING _____ B. WING _____	C 05/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRINITY HEALTHCARE CENTER	230 AIRLINE ROAD COLUMBUS, MS 39702

(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 697	Continued From page 15 16 residents sampled. Resident #29 Findings Include: Review of the facility policy titled, "Pain Management" with no revision date revealed under the "Policy ...The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the resident's goals and preferences" This review revealed under "Policy Explanation and Compliance Guidelines ...The facility utilizes a systematic approach for recognition, assessment, treatment and monitoring of pain ...k. Sighing, groaning, crying, breathing heavily; under "Pain Assessment: e. Determining factors that make the pain better or worse"; and under "Monitoring: 1. Reassess patients with pain regularly based on the facility's established intervals". On 05/28/24 at 11:03 AM, an observation revealed two staff members were leaving Resident #29's room with a bag of garbage and the resident was moaning loud enough that it could be heard from the hallway outside of her room. Upon entering the resident's room, the resident was sitting up in her wheelchair, dressed in personal clothes and continued making loud moaning noises with her mouth open at all times, her eyebrows were furrowed, and a single tear fell from her right eye. The resident was unable to be interviewed and could not answer questions. On 5/28/24 at 11:20 AM, an interview with Licensed Practical Nurse (LPN) #2 revealed the aides were just in there getting Resident #29 up out of bed and the LPN stated that they were	F 697	resident # 29 by the Registered Nurse. 2. The Interdisciplinary Team (IDT) determines that all residents unable to verbalize pain have the potential to be affected by the deficient practice. 3. On 5/30/2024 the IDT reviewed all residents with a Brief Interview for Mental Status (BIMS) of 7 or less and if these residents were unable to verbally express pain. Residents were then evaluated based on their diagnosis and history of as needed pain medication usage to determine if assessment was needed by Nurse Practitioner for routinely scheduled pain medication. All licensed nursing staff will be educated by 6/14/2024 by the Director of Nursing (DON) on the Pain Management Policy. Resident # 29 is being monitored each shift for non-verbal signs and symptoms of pain by staff assigned to her care. Beginning on 5/30/2024, DON reviewed documentation of Resident # 29's non-verbal signs and symptoms of pain at a minimum every three days. On 6/7/2024 a time adjustment was made to resident #29's routine pain medication. On 6/11/2024 resident # 29's routine pain medication was increased by NP based on review of non-verbal signs and symptoms of pain documentation and assessment review. 4. The DON and/or Administrator will complete 3 pain assessment audits a week for four weeks beginning 5/30/2024 then monthly for 3 months to ensure appropriate interventions for pain with nonverbal elders have been implemented. Resident # 29 and two additional resident's pain assessments will be	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255222	A. BUILDING _____ B. WING _____	C 05/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRINITY HEALTHCARE CENTER	230 AIRLINE ROAD COLUMBUS, MS 39702

(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 697	Continued From page 16 observed leaving the room around 11:00 AM. Record review of Resident #29's "Admission Record" revealed the resident was admitted to the facility on 3/11/24 with medical diagnosis that included Multiple Myeloma not having achieved remission and Secondary Malignant Neoplasm of Bone. An observation on 5/28/24 at 1:00 PM, revealed the resident sitting up in her wheelchair in the resident's room with continuous moaning that could be heard in the hallway and continued to have furrowed brows and facial grimacing. Record review of Resident #29's physicians orders revealed an order dated 3/15/24 for Hydrocodone-Acetaminophen tablet 5-325 milligrams (mg) by (via) PEG (Percutaneous Endoscopic Gastrostomy Tube) every 4 (four) hours as needed for pain. Record review of Resident #29's May 2024 Electronic Medication Administration Record (EMAR) revealed the resident has received 9 (nine) Hydrocodone pills as needed in the last 29 days with the last administration being 5/27/24 at 1:47 AM. An interview on 5/29/24 at 10:20 AM, with Resident #29's husband who is her representative revealed it is hard to tell when she is hurting so they just give her pain medicine sometimes. He stated she has Multiple Myeloma that deteriorates the resident's bones, so it hurts her when they have to move her. An interview on 5/29/24 at 10:45 AM, with Certified Nurse Assistant (CNA) #2 confirmed that	F 697	audited each time. The observation reports will be reviewed by the Quality Assurance Improvement Planning Committee on 6/19/2024, and thereafter, for at least 3 months, until consistent substantial compliance has been achieved as determined by the committee.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255222	A. BUILDING _____ B. WING _____	C 05/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRINITY HEALTHCARE CENTER	230 AIRLINE ROAD COLUMBUS, MS 39702

(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 697	Continued From page 17	F 697		

Resident #29 moans most of the time, but when they get her up or move her, she moans even louder. She stated that she has told the nurses before that she thinks the resident is hurting, but she has not told them that every time they get her up or move her that she moans out like this.

An interview on 5/29/24 at 11:00 AM, with LPN #2 and Registered Nurse (RN) #1 confirmed that Resident #29 moaned all of the time, but they give her pain medicine when her moaning increased or has gotten louder because that was how they could tell when she was hurting. They confirmed that the resident had a cancer that affected her bones, so it probably did hurt when she was moved or transferred. They revealed that the resident did not get pain medicine with transfers but could see how that would be a good idea.

An interview on 5/29/24 at 11:15 AM, with CNA #3 confirmed that Resident #29's moaning would increase when they got her up or moved her and she was sure it was because of pain.

An interview on 5/29/24 at 12:00 PM, with RN/Minimum Data Set (MDS) Nurse confirmed that Resident #29 had a diagnosis of Multiple Myeloma and movement probably increased the resident's pain. She revealed she did the pain assessment for Resident #29's Minimum Data Set (MDS) assessments and confirmed that the resident moans a lot. She stated that the only way to know for sure the resident is in pain is if her moaning increased, but there would be no way to tell what the pain level was on a scale of 1-10, because the resident is unable to verbalize that information. She stated that receiving a pain pill 9 times in the last 29 days was probably not

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255222	A. BUILDING _____ B. WING _____	C 05/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRINITY HEALTHCARE CENTER	230 AIRLINE ROAD COLUMBUS, MS 39702

(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 697	Continued From page 18	F 697		

enough for this resident. She stated that she feels like the resident is to a point where she could use a more continuous type of pain medication.

An interview on 5/29/24 at 1:55 PM, with Nurse Practitioner (NP) confirmed that Resident #29 had Multiple Myeloma that more than likely caused pain with movement. She revealed that on the resident's initial assessment in 3/2024, she discovered the resident had spasticity in her right posterior neck with pain and she started her on a muscle relaxer. She confirmed that the resident had PRN pain pills ordered, but it was hard to tell with this resident if she was in pain except that her moaning would change. She stated that maybe they should consider changing her order of PRN pain pills to be given before transfer or scheduled.

An interview on 5/29/24 at 3:30 PM, with the Director of Nurses (DON) confirmed that Resident #29 probably needs something scheduled for pain with a diagnosis of Multiple Myeloma. She confirmed that the resident moans almost all of the time, but her moaning does get a different pitch to it when they think she is in pain. She confirmed that it would be impossible for the resident to give them a pain scale of 1-10 or let them know if she is relieved from the pain medication. She stated that a resident with Multiple Myeloma probably needs more than 9 pain pills in 29 days for pain control.

Review of Resident #29's MDS with an Assessment Reference Date (ARD) of 3/18/24 revealed in Section C a Brief Interview for Mental Status (BIMS) score of 99, which indicated the resident is severely cognitively impaired and in

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255222	A. BUILDING _____ B. WING _____	C 05/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRINITY HEALTHCARE CENTER	230 AIRLINE ROAD COLUMBUS, MS 39702

(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 697	Continued From page 19 Section J that the resident had pain that is indicated with nonverbal sounds.	F 697		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the 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 facility policy review, the facility failed to safely store narcotics in the medication room refrigerator for one (1) of two (2) medication rooms in the facility. (100 hall medication room)	F 761	1. Refrigerated narcotics were immediately counted and secured. Maintenance was contacted and a lock box was affixed to the refrigerator in the north hall medication room. This was completed on 5/30/24.	6/19/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255222	A. BUILDING _____ B. WING _____	C 05/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRINITY HEALTHCARE CENTER	230 AIRLINE ROAD COLUMBUS, MS 39702

(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 761	Continued From page 20 Findings include: Review of the facility policy titled, "Controlled Substance Administration and Accountability", with an implementation dated of 10/2022, revealed it is the policy of this facility to promote safe, high quality patient care, compliant with state and federal regulations regarding monitoring the use of controlled substances. The facility will have safeguards in place in order to prevent loss, diversion or accidental exposure. An observation of the 100-hall medication room on 05/29/24 at 4:20 PM, with Licensed Practical Nurse (LPN) #1 revealed one vial of Ativan two (2) milligrams/one (1) milliliter in a clear plastic box in the refrigerator. The Ativan was not in a compartment secured to the refrigerator. This was confirmed by LPN #1. An observation and interview, on 05/30/24 at 9:10 AM, with the Director of Nursing (DON) confirmed the injectable Ativan was not in a separately locked permanently affixed compartment in the refrigerator. She stated that she understands that the box could easily be removed from the refrigerator. She stated she could see how it could get mixed up in all the things in the refrigerator and not be noticed if it was missing. A telephone interview, on 5/30/24 at 10:00 AM, with the Pharmacy Consultant revealed that they had discussed this in the past and he thought they had put what needed to be done in place.	F 761	2. Any elders receiving refrigerated schedule II or above narcotics have the potential to be affected by the deficient practice. 3. Lock box was affixed to medication room refrigerator for all schedule II or above narcotics requiring refrigeration to be stored. All licensed nursing staff that handle narcotics will be educated by 6/14/24 on affixed compartment storage and handling of controlled substances by Director of Nursing (DON) 4. Beginning on 5/30/2024, (DON), Administrator or Quality Assurance (QA) Nurse will audit medication room refrigerator and ensure Schedule II narcotics requiring refrigeration are stored appropriately in affixed lock box in refrigerator weekly 4 weeks then once a week times 2 months. Observation audits will be brought to the Quality Assurance and Performance improvement plan Committee (QAPI) meeting on 6/19/24 and thereafter, for at least 3 months, until consistent substantial compliance has been achieved as determined by the committee.	
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control	F 880		6/19/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255222	A. BUILDING _____ B. WING _____	C 05/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRINITY HEALTHCARE CENTER	230 AIRLINE ROAD COLUMBUS, MS 39702

(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 880	Continued From page 21	F 880		

The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.

§483.80(a) Infection prevention and control program.
The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:

§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255222	A. BUILDING _____ B. WING _____	C 05/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRINITY HEALTHCARE CENTER	230 AIRLINE ROAD COLUMBUS, MS 39702

(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 880	Continued From page 22 involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, record review, and facility policy review, the facility failed to store a respiratory suctioning device in a manner that prevented the possibility of the spread of infection for one (1) of two (2) residents with suction devices. Resident #23 Findings Include: Review of the facility policy titled "Infection Prevention and Control Program" undated, revealed under, "Policy: This facility has established and maintains an infection prevention	F 880	1. On 5/29/24 the unbagged yanker suction tool was disposed of. A new yanker suction tool was bagged and attached to suction machine and suction machine was removed from the floor. 2. All elders with an order for suction have the potential to be affected by this deficient practice. 3. Order review was done to determine any other elders requiring the use of suctioning equipment was completed by the Director of Nursing (DON). On 6/3/2024 all suction machines were	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255222	A. BUILDING _____ B. WING _____	C 05/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRINITY HEALTHCARE CENTER	230 AIRLINE ROAD COLUMBUS, MS 39702

(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 880	Continued From page 23 and control program designed to provide safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections as per accepted national standards and guidelines." An observation of Resident #23 on 5/28/2024 at 10:26 AM and 2:29 PM, revealed a suction machine with the attached tubing was placed on the floor beside the resident's bed, with an unbagged yankauer suction tool lying on the floor. Record review of the "Order Summary Report" for Resident #23 revealed an order dated 1/27/2024, "Bedside suction with yankauer as needed for increased secretions." An interview with Licensed Practical Nurse (LPN) #1 on 5/29/2024 at 10:24 AM, confirmed the suction device being on the floor and unbagged was an infection control concern and the suction device must be replaced with a new one. She revealed when respiratory equipment was not in use, it should be bagged to keep the device clean and prevent the spread of infection. An interview with the Director of Nursing (DON) on 5/29/2024 at 10:31 AM, revealed the purpose of keeping respiratory equipment in a bag when not in use was to keep the items clean to prevent the spread of infection. Record review of the "Admission Record" revealed the facility admitted Resident #23 on 6/21/2022 with a medical diagnosis of unspecified dementia.	F 880	placed in sealable plastic bins. All licensed nursing staff will be educated, by the Quality Assurance Nurse on storage of respiratory equipment when it is not in use by 6/14/2024. 4. The DON began auditing, two times a week, on 5/29/2024 for proper storage of suction machines when not in use. Beginning on 6/3/2024 DON, Medical Records Licensed Practical Nurse or Quality Assurance (QA) Nurse will audit for proper storage of suction machine equipment, when it is not in use, 2 times a week for 4 weeks and then weekly for 2 months. Observation audits will be brought to the Quality Assurance and Performance Improvement Plan Committee meeting on 6/19/2024 and thereafter, for at least 3 months, until consistent substantial compliance has been achieved as determined by the committee.	