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 _____	02/20/2020

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 recertification survey along with a complaint, CI MS #16619 survey from 02/18/2020 to 2/20/2020. During the survey, the SA did not substantiate the complaint CI MS #16691 for the allegation of abuse and no deficiencies were cited related to the complaint. The SA did determine, during the survey, the facility was not in compliance with the requirements of participation for Medicare and Medicaid and cited F641 and F812. The facility was licensed for 60 beds and had a census of 59 at the time of the survey.	F 000		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on staff interview, record review, and facility policy review, the facility failed to submit an accurate Minimum Data Set (MDS) assessment regarding medication administration for one (1) of 15 MDSs reviewed. Resident #27. Findings include: Review of facility policy titled, "Resident Assessment - RAI", dated 10/2016, revealed, this facility makes a comprehensive assessment of each resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. Record review of Resident #27's Minimum Data	F 641	1. The assessment for Resident #27 was corrected on 2/19/2020, by the Minimum Data Set Nurse (MDS) to reflect the use of antibiotics as ordered by her physician. 2. This facility has determined that all elders are at risk for the deficient practice. 3. An in-service was conducted by the Director of Clinical Support on 2/27/2020, with the MDS Director, MDS Nurse, Registered Dietitian, Director of Therapy, Activities Director, and Social Services Director addressing the importance of accurately assessing the elders and correctly entering the assessment into the electronic medical record.	4/25/20

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

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F 641	Continued From page 1 Set (MDS) Section N, dated 12/23/2019, revealed Resident #27 received an anticoagulant medication for seven of the seven (7 of 7) look back day period. Review of Resident #27's medical record revealed Resident #27 did not have a physician's order for the administration of an anticoagulant medication. The medical records did not reveal Resident #27 had received an anticoagulant medication. On 2/19/2020 at 10:00 AM, the facility's Minimum Data Set (MDS) Coordinator, stated she was responsible for entering Resident #27's information into the MDS system. The MDS Coordinator stated during the 12/23/2019 MDS assessment, the resident was not receiving an anticoagulant medication, but she was receiving an antibiotic. The MDS Coordinator stated she failed to accurately enter the medication as an antibiotic, as ordered, instead of an anticoagulant. On 02/20/20 at 1:39 PM, during an interview, the facility's Director of Nursing (DON) confirmed Resident #27's MDS was inaccurately completed and submitted. She stated accurate completion of the MDS information is important for proper documentation of the resident's needs and care areas.	F 641	4. The MDS Director and MDS Nurse conduced audits beginning 2/21/2020, for three elders per week for three weeks, and one elder per week for three weeks. These elder's medical records were audited to ensure that the Medication Administration Record and Section N of the Minimum Data Set was coded accurately during the observation period. Beginning 3/25/2020, the auditing reports were reviewed by the Quality Assurance Committee and will continue to be reviewed monthly until such time consistent substantial compliance has been achieved as determined by the committee.	
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal,	F 812		4/25/20

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F 812	Continued From page 2 state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and facility policy review, the facility failed to provide a safe and clean dietary environment for the storage and service of foods to the residents for two (2) of two (2) dietary tours. Findings include: Review of the facility policy #4079, titled, "Dining Services - Cleaning Ovens" dated 02/01/2020, revealed the objective was to ensure equipment is cleaned and in good working condition and ovens will be cleaned and sanitized weekly. This is the responsibility of the dining service cooks/utilities. During initial tour of the Dietary Department, on 2/18/2020 at 10:30 AM, an observation revealed in the walk-in refrigerator with these undated and unlabeled food items: A container of eight (8) boiled eggs, one bowl of chopped meat, three (3) containers of pureed foods, a bowl of scrambled eggs, approximately one-half of a nine (9) to 11	F 812	1. On 2/18/2020, all not labeled/dated foods were removed from the walk-in cooler by the Director of Dining Services. On 2/19/2020, the ovens at Trinity Healthcare were cleaned by the Director of Dining Services. On 2/18/2020, all not labeled/dated items were removed from the stand-alone cooler by the Registered Dietician. 2. This facility has determined that all elders are at risk for the deficient practice. 3. All dietary staff were in-serviced on 2/18/2020, by the Director of Dietary Services on labeling and dating food and proper cleaning of the ovens. 4. Beginning 2/19/2020, the Registered Dietician and Director of Dining Services will provide weekly audits of the walk in and reach in coolers to ensure proper storage of foods, and cleanliness of the ovens. Beginning 3/25/2020, the auditing reports will be reviewed by the Quality Assurance Committee monthly until such	

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F 812	Continued From page 3 pound turkey breast and ham. These items were removed by the Director of Dining Services (DDS) at this time. An observation, on 2/18/2020 at 10:45 AM, of the stand-alone refrigerator near the serving line, revealed trays containing two (2) glasses of water, one (1) glass of tea, two (2) bowls of pureed bread, two (2) bowls of pudding, two (2) glasses of buttermilk, six (6) glasses of tomato juice, one (1) glass of strawberry Ensure, four (4) glasses of nectar thick sweetened tea, and four (4) glasses of nectar thickened water without a date or label. On the bottom shelf there was eight (8) cups of mandarin oranges and one (1) cup of sliced peaches not covered or dated. One of the cups of oranges had a piece of grated cheese in it that fallen out of a salad that was on the shelf above it. The Registered Dietician (RD) removed the cup of mardarin oranges containing the cheese from the refrigerator. There was a two quart pitcher of tea and a two quart pitcher with a small amount of tomato juice barely covering the bottom of the pitcher on the top shelf. Neither of these was labeled or dated. The RD removed the pitcher of tomato juice from the refrigerator. An interview, on 2/18/2020 at 10:50 AM, with the RD, confirmed that all food and drinks should be labeled and dated. She stated she guessed they weren't because they usually throw away everything left over after the meal. She confirmed the cheese should not have been in the bowl of mandarin oranges. She stated that she didn't know why the pitcher of tomato juice was in the refrigerator because it was empty. An interview, on 2/18/2020 at 10:55 AM, with the DDS, confirmed that containers of food put in the	F 812	time consistent substantial compliance has been achieved as determined by the committee.	

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	255222	A. BUILDING _____ B. WING _____	02/20/2020

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F 812	Continued From page 4	F 812		

refrigerators should be labeled and dated. He stated some of the things like the scrambled eggs should not have been in the refrigerator, they should have been thrown away.

An observation, on 2/19/2020 at 11:45 AM, revealed the entire inside of the convection oven was covered with a dark brown coating. The oven racks were coated with a black charred material and the door ledge was covered with black flakes and brownish food particles.

During an interview, on 2/19/2020 at 12:30 PM, with the Director of Dining Services (DDS), he stated the convection oven needed to be taken care of immediately. He stated the carbon build-up and charred food could cause a fire. The DDS stated the kitchen staff should do daily cleaning and he thought deep cleaning was done by maintenance because they did not have the chemicals in the kitchen needed for deep cleaning.

An interview, with the RD, on 2/19/2020 at 12:35 PM, revealed no prior cleaning schedules were available because the new company people had come in and thrown everything away last night.

An interview, on 2/20/20 at 12;20 PM, with the Administrator (ADM), revealed the ovens had been cleaned last night. The ADM stated he had a smoker at his house that was cleaner than the oven. He stated that he eats in the kitchen and he did not want to get sick and he did not want his residents to get sick. He stated the DDS is responsible for looking at and monitoring these kitchen problems. The ADM stated the new company had cleaned out all their previous papers, schedules and policies.

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	255222	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**02/20/2020**

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K 000	INITIAL COMMENTS 42 CFR 483.70(a) The facility must meet the applicable provisions of the 2012 (existing) Edition of the Life Safety Code (LSC) of the National Fire Protection Association (NFPA) ...	K 000		
K 211 SS=D	Means of Egress - General CFR(s): NFPA 101 Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 This REQUIREMENT is not met as evidenced by: Based on observations and interviews, the facility failed to properly inspect fire doors as required by S&C Letter 17-38. This deficiency practice affected one (1) of four (4) smoke compartments in the facility on the day of survey. Findings include: On 2/20/2020 at 10:45 AM, observation revealed four (4) fire doors in the facility. The facility could not provide documentation showing the annual inspection of the fire doors in the facility. The four (4) fire doors were separating the nursing home from the personal care home in the facility.	K 211	K 211 1. The facility will meet the applicable provisions of the 2012 Edition of the Life Safety Code (LSC) of the National Fire Protection Association (NFPA) 2. The facility contacted the vendor on 03/24/2020 and requested their service to inspect the four fire doors separating the nursing home from the personal care home. The inspection is scheduled for 4/15/2020. 3. All Elders have the potential to be affected by this deficient practice. 4. The facility Maintenance Director will	4/15/20

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K 211	Continued From page 1	K 211	contract with the vendor to perform annual inspections of the fire doors separating the nursing facility from the personal care home. This plan of correction is integrated into the quality assurance system. QA committee will monitor at the next QA meeting for continued compliance. Completion Date: April 15, 2020 Responsible person: Maintenance Director	

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E 000	Initial Comments ********** Survey conducted on 02/20/20 reveals the above facility meets all applicable Federal, State and local emergency preparedness requirements. No deficiencies were cited.	E 000		

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