

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

PRINTED: 05/01/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255222	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/21/2019
NAME OF PROVIDER OR SUPPLIER TRINITY HEALTHCARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 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 at the facility from 3/19/19 to 3/19/19. During the survey, the SA determined the facility was in compliance with Medicare and Medicaid requirements for participation. At the time of survey, the census was 56, and the facility held a license for 60 beds.	F 000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

04/12/2019

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.

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

PRINTED: 05/01/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255222	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 03/20/2019
NAME OF PROVIDER OR SUPPLIER TRINITY HEALTHCARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 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
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 352 SS=F	Sprinkler System - Supervisory Signals CFR(s): NFPA 101 Sprinkler System - Supervisory Signals Automatic sprinkler system supervisory attachments are installed and monitored for integrity in accordance with NFPA 72, National Fire Alarm and Signaling Code, and provide a signal that sounds and is displayed at a continuously attended location or approved remote facility when sprinkler operation is impaired. 9.7.2.1, NFPA 72 This REQUIREMENT is not met as evidenced by: Based on observation and testing the fire alarm system, the facility failed to provide automatic sprinkler system supervisory signals in accordance by NFPA 101 Chapter 9.7.2.1; NFPA 72 Chapter 17.12.2. The deficient practice affected three (3) of three (3) smoke compartments and all residents in facility on the day of survey. Findings include: During testing on 3/20/19 at 10:45 AM, observation revealed the initiate of the fire sprinkler system (via inspector test valve) did not activate the fire alarm system. The fire sprinkler system was incapable of activating the fire alarm	K 352	This plan of correction in response to the Statement of Deficiencies demonstrates our good Faith and desire to continue to improve the quality of care and services rendered to our elders. However, the answers do not constitute an admission that the citations are accurate in any respect The Plan of Correction constitutes a written allegation of substantial compliance with Federal Medicare and Medicaid requirements K 352 The facility will meet the applicable provisions of the 2012 Edition of the Life Safety Code (LSC) of the		4/12/19

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

04/12/2019

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.

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

PRINTED: 05/01/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255222	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 03/20/2019
NAME OF PROVIDER OR SUPPLIER TRINITY HEALTHCARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 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
K 352	Continued From page 1 system within the minimum requirement of 90 seconds. The sprinkler inspector valve test was performed for the time duration of 149 seconds. The finding was acknowledged by the Administrator and Maintenance Supervisor verified this observation during the exit interview on 3/20/19.	K 352	National Fire Protection Association (NFPA) 1. The facility contacted the vendor (P&M Automatic Fire Protection) on 03/21/2019 and requested service for the sprinkler system to determine the cause of the delay to the fire alarm system. P&M came to the facility and observed there were dirt dauber nest in the outside drain fittings on the inspectors test valve. The nest were removed and the system was checked 4 times to ensure proper function. The alarm delay time did not exceed 39.2 seconds. 2. All Elders have the potential to be affected by this deficient practice. 3. The facility Maintenance Director will monitor the inspectors test valve, weekly for 4 weeks to ensure proper function and the fire alarm engages in less than 90 seconds. The system will then be checked monthly to ensure that the fire alarm engages in less than 90 seconds. The sensor will be checked visually to ensure there are no insect next present. 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 12, 2019 Responsible person: Maintenance Director		

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

PRINTED: 05/01/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255222	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/20/2019
NAME OF PROVIDER OR SUPPLIER TRINITY HEALTHCARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 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	
E 000	Initial Comments *EMERGENCY PREPAREDNESS* Survey conducted on 3/20/19 reveals the above facility meets all applicable Federal, State and local emergency preparedness requirements. No deficiencies were identified.	E 000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

04/12/2019

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.