

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 195302	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/25/2024
NAME OF PROVIDER OR SUPPLIER Trinity Trace Community Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 612 Holy Trinity Drive Covington, LA 70433	

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)
<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure each resident receives an accurate assessment.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46975</p> <p>Based on interviews and record reviews, the facility failed to ensure the MDS assessment accurately reflected the resident's status for 2 (#1 and #107) residents out of a total of 25 sampled residents by failing to ensure:</p> <ol style="list-style-type: none"> 1. Resident #1 was coded correctly for the use of an antidiuretic; and 2. Resident #107 was coded correctly for discharge. <p>Findings:</p> <ol style="list-style-type: none"> 1. <p>Review of Resident #1's Clinical Record revealed she was admitted to the facility on [DATE].</p> <p>Review of Resident #1's Quarterly MDS with an ARD of 07/23/2024 revealed Section N:G: Diuretic: No.</p> <p>Review of Resident #1's Physician Orders revealed the following:</p> <p>Start date: 05/21/2024, End Date: 09/08/2024: Furosemide 20 mg</p> <p>Give 20 mg by mouth two times a day.</p> <p>On 09/24/2024 at 9:48 p.m., an interview was conducted with S4CCC. She stated she was responsible for the July 2024 Quarterly MDS assessment. She verified Resident #1 had a Physician's Order for Furosemide 20 mg twice daily with a start date of 05/21/2024. She reviewed Resident #1's Quarterly MDS and confirmed Section N:G was not coded for taking a diuretic and should have been.</p> <p>On 09/25/2024 at 3:00 p.m., an interview was conducted with S1DON. She confirmed if Resident # 1 was taking Furosemide during the look back period then the Quarterly MDS should have been coded for it.</p> <ol style="list-style-type: none"> 2. <p>(continued on next page)</p>

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
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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of Resident #107's Clinical Record revealed she was admitted to the facility on [DATE] and discharged on [DATE].</p> <p>Review of Resident #107's Discharge MDS with an ARD of 08/26/2024 revealed Section A2105 Discharge Status: Short Term General Hospital.</p> <p>Review of Resident #107's Discharge Summary dated 08/26/2024 revealed the resident was discharged to a local assisted living facility.</p> <p>On 09/24/2024 at 12:38 p.m., an interview was conducted with S3CCC. She stated she was responsible for the MDS Assessments. She verified Resident #107 she was discharged to an assisted living facility. She reviewed Resident #107's Discharge MDS and confirmed Section A2105 indicated the resident was discharged to the hospital, and should have been coded for discharge to assisted living.</p> <p>On 09/24/2024 at 12:55 p.m., an interview was conducted with S1DON. She verified Resident #107 was discharged to a local assisted living facility. She reviewed Resident #107's MDS and confirmed she was coded for being discharged to the hospital and should have been coded for discharge to an assisted living facility.</p> <p>47173</p>

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>47191</p> <p>Based on record review, observations, and interviews, the facility failed to provide pharmaceutical services, including procedures that assure the dispensing and administering of all drugs and biologicals, to meet the needs of each resident. The facility failed to ensure insulin pens were primed prior to administration of insulin per manufacturer's guidelines for 3 of 3 (#11, #30, and #76) residents observed for insulin administration.</p> <p>Findings:</p> <p>Review of the facility's policy titled Insulin/Insulin Flexpens and Insulin Documentation dated 01/29/2013, revealed the following, in part:</p> <p>FlexPen Insulin Administration</p> <p>7. Air Shot steps: turn the device dose selector to 2U, holding pen with needle up, tap cartridge a few times to move any air bubbles to the top of the device, complete air shot by pressing the injector push button all the way in (the dose selector will return to 0), a drop of insulin should be present on the needle tip.</p> <p>Review of the manufacturer's insert for Insulin Aspart FlexPen (Novolog) revealed the following, in part:</p> <p>Giving the airshot before each injection- Before each injection small amounts of air may collect in the cartridge during normal use. To avoid injecting air and to ensure proper dosing:</p> <p>E. Turn the dose selector to select 2 units</p> <p>F. Hold your Novolog Flexpen with the needle pointing up. Tap the cartridge gently with your finger a few times to make any air bubbles collect at the top of the cartridge</p> <p>G. Keep the needle pointing upwards, press the push button all the way in. The dose selector returns to 0. A drop of insulin should appear at the needle tip.</p> <p>Resident #11</p> <p>Review of Resident #11's current Physician Orders revealed, in part, an order for Insulin Aspart FlexPen Solution Pen-Injector 100Unit/ML(InsulinAspart) Inject as per sliding scale.</p> <p>On 09/24/2024 at 11:16 a.m., an observation was made of S7LPN preparing and administering Resident #11's Insulin Aspart FlexPen. S7LPN dialed the Insulin Aspart FlexPen to 6 units. S7LPN did not prime the Insulin Aspart FlexPen prior to administration to Resident #11.</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 09/24/2024 at 11:17 a.m., an interview was conducted with S7LPN. S7LPN confirmed she did not prime the Insulin Aspart FlexPen prior to administration. S7LPN stated she was unaware the Insulin Aspart FlexPen needed to be primed prior to administration.</p> <p>Resident #30</p> <p>Review of Resident #30's current Physician Orders revealed, in part, an order for Insulin Aspart Subcutaneous Solution Pen-injector 100Unit/ML(InsulinAspart) Inject as per sliding scale.</p> <p>On 09/24/2024 at 10:59 a.m., an observation was made of S6LPN preparing and administering Resident #30's Insulin Aspart. S6LPN dialed the Insulin Aspart FlexPen to 2 units and administered it to Resident #30. S6LPN did not prime the Insulin Aspart FlexPen prior to administering to Resident #30.</p> <p>On 09/24/2024 at 11:00 a.m., an interview was conducted with S6LPN. S6LPN confirmed she did not prime the Insulin Aspart FlexPen prior to dialing the insulin dose. S6LPN stated she was unaware the Insulin Aspart FlexPen needed to be primed prior to administration.</p> <p>Resident #76</p> <p>Review of Resident #76's current Physician Orders revealed, in part, an order for Novolog Injection Solution 100 Unit/ML(Insulin Aspart) Inject as per sliding scale. Remove space</p> <p>On 09/24/2024 at 10:27 a.m., an observation was made of S8LPN preparing and administering Resident #76's Novolog (Insulin Aspart). S8LPN dialed the Insulin Aspart FlexPen to 2 units and administered it to Resident #76. S8LPN did not prime the Insulin Aspart FlexPen prior to administering to Resident #76.</p> <p>On 09/24/2024 at 10:28 a.m., an interview was conducted with S8LPN. S8LPN confirmed she did not prime the Insulin Aspart FlexPen prior to dialing the insulin dose. S8LPN stated she was unaware the Insulin Aspart FlexPen needed to be primed prior to administration.</p> <p>On 09/24/2024 at 1:00 p.m., an interview was conducted with S1DON. She reviewed the manufacturer's insert for Insulin Aspart FlexPen and confirmed it required a priming of 2 units of insulin prior to administering each dose.</p> <p>On 09/24/2024 at 1:05 p.m., an interview was conducted with S5QI. She confirmed Insulin Aspart FlexPen required a priming of 2 units of insulin prior to administering each dose.</p>

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>46975</p> <p>Based on observations and interviews, the facility failed to ensure drugs and biologicals used in the facility were stored in accordance with currently accepted professional principles. The facility failed to ensure:</p> <ol style="list-style-type: none"> 1. Temperatures were documented for the medication refrigerator in 1 of 1 (Med Room a) medication storage rooms observed; and 2. Expired medications were not available for administration to residents in 1 (Med Cart c) of 4 (Med Cart a, Med Cart b, Med Cart c, and Med Cart d) medication carts observed. <p>Findings:</p> <p>An observation was made of Med Room a on 09/23/2024 at 9:33 a.m. with S1DON. Review of the Daily Refrigerator Task Log dated September 2024 for the refrigerator located in Med Room a revealed the only dates in which temperatures were documented were on 09/02/2024, 09/03/2024, 09/04/2024, 09/08/2024, 09/14/2024, 09/15/2024, and 09/21/2024.</p> <p>An interview was conducted on 09/23/2024 at 9:37 a.m. with S1DON. She reviewed the Daily Refrigerator Task Log and confirmed the temperatures of the medication refrigerator should have been documented daily by the night shift nurses, and were not.</p> <p>An observation was made of Med Cart c on 09/23/2024 at 9:44 a.m. with S2LPN. An observation was made of a box of Artificial Tear eye drops with an open date of 08/01/2024. There was an expiration date of 03/2024 on both the bottle and the box of the Artificial Tears. The bottle of the Artificial Tears was observed to be 3/4 empty.</p> <p>An interview was conducted on 09/23/2024 at 9:46 a.m. with S2LPN. She verified there was an expiration date of 03/2024 on the box and bottle of the Artificial Tears eye drops. She verified there was a written open date on the Artificial Tears of 08/01/2024, and the eye drops were available for use. She stated the nurse who opened the Artificial Tears should have checked the expiration date before administering the eye drops. She confirmed expired medications, including eye drops, should be discarded and not administered to residents.</p> <p>An interview was conducted on 09/23/2024 at 10:25 a.m. with S1DON. She was notified of the above findings. She confirmed expired eye drops should be discarded and not be administered to residents.</p>		