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	05/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Trinity Healthcare Center	230 Airline Road Columbus, MS 39702

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. 47874 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. 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 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. (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 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 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.