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

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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 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44804 Based on staff interview, record review and facility policy review, the facility failed to send a written notice to the resident representative regarding a resident being transferred to the hospital for one (1) of three (3) residents reviewed for hospitalization s. Resident #8 Findings Include: Review of the facility policy titled, Transfer and discharge date d 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. Review of Resident #8's Admission Record revealed the resident was admitted to the facility on [DATE] with medical diagnoses that included Unspecified Dementia, mild with other behavioral disturbances.

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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F 0656 Level of Harm - Actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44804 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 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. 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. (continued on next page)

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F 0656 Level of Harm - Actual harm Residents Affected - Few	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 [DATE] 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 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. 47874 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 11/14/2023 with a medical diagnosis of unspecified dementia.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. 47874 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 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.

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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 0697 Level of Harm - Actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44804 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 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 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 [DATE] 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. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	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 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 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. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	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 Section J that the resident had pain that is indicated with nonverbal sounds.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. 37399 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) 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.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 47874 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 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.