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 _____	C 01/02/2020

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 a complaint survey for CI MS # 16461, at the facility on 1/2/2020, related to an entity reported incident for abuse and neglect. During the survey, the SA determined the facility was not in compliance with the requirements of participation for Medicare and Medicaid, and cited a deficiency at F600. The census at the time of the survey was 56, and the facility was licensed for 60 beds.	F 000		
F 600 SS=D	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on record review, staff interview and facility policy review, the facility failed to ensure Resident #1 was free from abuse and/or neglect, for one of five residents reviewed for abuse and neglect. Findings include:	F 600	F600 SS=D On 11/28/19 at 1:03 PM, Resident #1's call light was placed back into proper function by Registered Nurse #2. One hundred percent (100%) of all Elder's call lights, including empty beds, were visually	2/3/20

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

Electronically Signed | 01/24/2020

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F 600	Continued From page 1 Review of facility's policy titled, "Abuse, Neglect and Exploitation - 2019", revealed: It is the policy of this facility to provide protection 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. Neglect is defined as failure of the facility, its employees, or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress. Review of the facility's written report and investigation, dated 12/2/19, revealed Registered Nurse (RN) #2 entered Resident #1's room, on 11/28/19 at 1:00 PM, to administer medications. The report indicated RN #2 was informed at that time by Resident #1 that she had been trying to call for help. The investigative report indicated RN #2 found the call light within the resident's reach but found that the end that plugs into the wall was on the floor and a drinking straw was inserted into the call box. The facility initiated an investigation at this time and determined by review of the camera log and that call light log that Licensed Practical Nurse (LPN) #3 was the last employee seen entering the room while the call light was functioning. The findings of the report revealed there was enough evidence to substantiate that LPN #3 was willfully neglectful of the resident. LPN #3's employment was terminated because of the incident on 12/5/19. Review of the facility's Call Light investigation for the video camera revealed there was a staff person in Resident #1's room at least every 30 minutes to an hour at the time the resident was in	F 600	checked on 11/28/19 to confirm correct attachment to the call system by Registered Nurse #2 and the Registered Nurse Clinical Manager. Resident #1 was assessed on 11/28/19 at 1:04 PM for any unmet needs by Registered Nurse #2. Resident #1's heat was adjusted as requested on 11/28/19 at 1:05 PM by Registered Nurse #2. All the Elders were identified to have the potential to be affected by this deficient practice. Direct care staff including Certified Nursing Assistants and Licensed Practical Nurses were notified by the Clinical Manager on 11/28/2019 that tampering with call lights would result in termination and would be reported to the Mississippi State Department of Health and the Attorney General's office. On 12/2/2019 an Abuse and Neglect in service was conducted by the Director of Nursing, the Registered Nurse Clinical Manager, and the Quality Assurance nurse. Certified Nursing Assistants, Licensed Practical Nurses, Registered Nurses, Dietary Staff, Registered Dietitian, Dietary Manager, Housekeeping Staff, Laundry Staff, Maintenance Staff, Department Heads, Minimum Data Set Nurses, Activity Director, Social Services Director, Therapy Staff, Chaplin, the Medical Director and the Pharmacy Consultant were included in the training. Visual audits of the twenty-five to thirty call light cords were conducted beginning on	

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F 600	Continued From page 2 her room. There were times the resident was out of her to the lobby, dining room, and hallways. There were times when staff would go in, and leave out within a minute or two to get supplies or a lift. Review of the Call Log and Video Log Summary revealed a call from Resident #1, on 11/28/19 at 3:23 AM, that lasted 12 seconds. The video log showed LPN #3 entered Resident #1's room at 3:24 AM. The call light was turned off and 18 seconds after LPN #3 entered the resident's room the call light came back on for 12 seconds and at 3:26 AM, LPN #3 was seen leaving the room. There was no further recorded call light activations on the summary log until 1:03 PM on 11/28/19. The video log revealed staff entering and exiting the room during the hours of 3:23 AM and 1:03 PM. An interview with the Administrator, on 1/2/2020 at 11:30 AM, revealed an investigation was initiated as soon as the disabled call light was found. Resident #1's daughter was notified, and she requested that her mother not be informed of the intentional disabling of her call light. The Administrator stated the request was honored. The Administrator stated that initially LPN #3 denied any knowledge of the disabled call light, but during their second conversation (by phone with a witness) she admitted she had done wrong and was ashamed of what she had done. Upon reviewing all the information, LPN #3 was terminated. Review of the facility's Corrective Action Form, dated 12/4/19, revealed LPN #3 was discharge, and the Nature of the Incident was for neglect.	F 600	December 2nd, 2019, five (5) days per week for one week and then weekly for four (4) weeks by the Clinical Manager, the Quality Assurance Nurse, and the Director of Nursing. This review of the call light cords was completed on January 31st, 2020. Beginning on 12/1/19, a review of the Call Summary Report from the Call Light System was conducted by the Administrator five (5) days per week for one week and three (3) days a week for three (3) weeks. Beginning 1/6/2020, Visual audits and Call Summary Report reviews will be conducted monthly for six (6) months. On 1/6/2020 this plan of correction is integrated into the quality assurance system. Quality Assurance Committee will monitor the effectiveness and make suggestions and changes as needed at the quarterly Quality Assurance meeting.	

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F 600	Continued From page 3	F 600		

Review of an email, dated 1/2/20 at 3:36 PM, revealed the Administrator notified the Mississippi Board of Nursing regarding the incident involving LPN #3 and Resident #1's call light disablement.

A phone interview with LPN #3, on 1/2/2020 at 1:55 PM, revealed she stated she did not have any knowledge of how the straw ended up in the call light system. LPN #3 stated she did not put it there and she does not know who did. She stated she informed the Administrator of that during their first interview. LPN #3 stated she also spoke with the Administrator by phone and informed him she was having a bad night that night due to having her finger crushed in her car door and other personal problems concerning her son. LPN #3 stated she never admitted to disabling Resident #1's call light.

Review of the Hours Worked Simplified Report, dated 11/28/19, revealed LPN #3 worked the 11 PM to 7 AM shift.

An interview with Registered Nurse (RN) #2, on 1/3/2020 at 2:45 PM, revealed she found the disabled call light when she went in to give medications. RN #2 stated the call light was within reach, but she noticed the call light was unplugged and laying on the floor. She stated a drinking straw was in the call box. RN #2 stated the curtain was blocking the call light system from view.

Review of the facility's in-service records revealed an in-service was provided to the staff, on 3/26/19, on Abuse and Neglect. Review of the sign in sheet revealed LPN #3's signature was on the sheet. The facility also provided an in-service to the staff, on 2/2/20, regarding Abuse and

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F 600	Continued From page 4 Neglect. Review of Resident #1's Face Sheet revealed Resident #1 was admitted by the facility, on 3/19/2015 with diagnoses which included, Heart Failure, Osteoarthritis, and Muscle Weakness. Review of the Intake Information form revealed Resident #1 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated Resident #1 was cognitively intact.	F 600		