STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255348	A. BUILDING _____ B. WING _____	C 08/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TREND HEALTH & REHAB OF MERIDIAN LLC	517 33RD STREET MERIDIAN, MS 39305

(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 Complaint Investigation (CI), MS #22214, at the facility on 8/14/23. The SA investigated the Facility Reported Incident (FRI) related to employee to resident abuse/exploitation. During the survey, the SA determined the facility was not in compliance with the requirements of participation in Medicare and Medicaid and cited F602. Based on the facility's implementation of corrective actions on 7/28/23, the State Agency (SA) determined the deficiency to be Past Non-Compliance (PNC) and the deficiency was corrected as of 7/29/23, prior to the SA's first entrance on 8/14/23. The facility was licensed for 58 beds and had a census of 53 at the time of survey.	F 000		
F 602 SS=D	Free from Misappropriation/Exploitation CFR(s): 483.12 §483.12 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. This REQUIREMENT is not met as evidenced by: Based on interview, record review, facility investigation and policy review, the facility failed to protect a resident from misappropriation of property for one (1) of four (4) residents sampled. Resident #1 Findings include:	F 602	Past noncompliance: no plan of correction required.	

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

Electronically Signed | 08/22/2023

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F 602	Continued From page 1	F 602		

A review of the facility's policy, "Abuse Policy and Procedure", dated 1/24/22, revealed " ...Each resident of this facility has the right to be free from verbal, sexual, physical and mental abuse, involuntary seclusion, corporal punishment, neglect and/or misappropriation of resident property ..."

A review of the facility's policy "Vulnerable Adult Act" dated 3/21/22 revealed, "A 'Vulnerable Adult' is any adult person unable to care for his or her self due to a physical or mental decline ...Any nursing home resident is considered to be a vulnerable adult ...the following situations are considered CRIMES OF ABUSE against a vulnerable adult ...5. Theft or misuse of a resident's personal belongings, personal funds (sic), or bank account ...It is the policy of this facility that no employee shall accept any gifts, money, or things from a resident ..."

Record review of the facility's investigation revealed that it was reported to the facility on 7/27/23 that a Certified Nurse Aide (CNA) had received cash from a resident and that she had sent him an explicit video to his cell phone. The Administrator in Training (AIT) and the Preceptor interviewed the CNA involved and she admitted that she sent the resident an explicit video. The AIT and Preceptor also interviewed the resident and he denied that he gave the CNA any money.

On 8/14/23 at 10:30 AM, in an interview with the Administrator in Training (AIT), he stated that the facility reported the incident of a CNA that had accepted money and had exchanged text messages with a resident, which included a video, but the CNA had claimed she was partially

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F 602	Continued From page 2	F 602		

clothed in the video. The AIT reported that the CNA involved was a newly hired had received her certification in December of 2022. He explained that the CNA alleged she had financial problems with making a car payment. He further explained that the Attorney General's Office (AGO) had visited the facility and had investigated the event. He said that although the AGO was able to obtain an interview in which the resident claimed he had given the CNA approximately $300, the resident denied the event happened when the facility interviewed him. He confirmed the facility provided in-services regarding abuse and the Vulnerable Adult Act and also had an emergency Quality Assurance Performance Improvement (QAPI) meeting to discuss the event and what measures would be implemented.

On 8/14/23 at 11:30 AM, in an interview with the Administrator, she stated that she completed one on one in-services with all staff and had them to sign the abuse policy and the vulnerable adult act. She stated that the amount of money that was given to the CNA by the resident had been inconsistent because the resident denied giving any money to the CNA and the CNA had originally stated the amount was $60, but then told the AGO it was $60 plus $281.

On 8/14/23 at 1:10 PM, in an interview with CNA #2, she stated that she had received a phone call from CNA #1 because she wanted to know if people were talking about her. CNA #1 told CNA #2 that Resident #1 had given her $481 to pay her car note. CNA #2 said that she knew this was not right, so she called the facility and reported what had been told to her by CNA #1.

On 8/14/23 at 1:22 PM, in an interview with CNA

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F 602	Continued From page 3	F 602		

#1, she confirmed that she took money from the resident. She stated that Resident #1 gave her cash money one evening when she was taking in his supper tray. She said Resident #1 said, "Here you go for doing a good job" and she expressed that she intended to pay him back for the money. She said this happened at the first of July but was unable to recall an exact date and she had told him that this money was going to be used for her car note. She explained the resident would often text her, but she usually did not text him back. She confirmed that she received training upon hire related to abuse of residents and the Vulnerable Adults Act.

On 08/14/2023 at 2:15 PM, during an interview with Resident #1, he stated he was aware of the situation, but it was all false. Resident #1 said there was no proof of any of the allegations and that no money had been transferred to anyone from him and that it was all "lies".

Review of the personnel file for CNA #1 revealed an "Employee Checklist" which indicated she had received training on the Vulnerable Adults Act. CNA signed acknowledgement of Resident's Rights signed 6/20/23. CNA #1 signed and dated the "Vulnerable Adult Act" on 6/20/23. CNA #1 signed and dated acknowledgement of the Abuse Policy and Procedure on 6/20/23.

Record review of the "Admission Record" revealed the facility admitted the Resident #1 on 1/17/23 with diagnoses that included Major Depressive Disorder.

A record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 7/18/23 revealed Resident #1 had a

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F 602	Continued From page 4	F 602		

Brief Interview for Mental Status (BIMS) score of 15, which indicated he was cognitively intact.

Based on the facility's implementation of corrective actions on 7/28/23, the State Agency (SA) determined the deficiency to be Past Non-Compliance (PNC) and the deficiency was corrected as of 7/29/23, prior to the SA's first entrance on 8/14/23.

Validation:

On 8/14/23, the SA validated through staff interviews, record review, and facility policy review, the facility began an immediate investigation when the suspicion of misappropriation of the resident's money occurred.

A review of the Monthly QAPI meeting minutes revealed the facility held a QAPI meeting on 7/28/23 at 10:00 AM, in which the Infection Preventionist (IP) was out of the facility for this emergency meeting and the Medical Director attended via phone. The SA verified through interview with the DON and Social Services Director that they attended the QAPI meeting to discuss the situation and the facility policies related to abuse were discussed and there were no changes needed. The QAPI meeting concluded that the Plan of correction was to in-service all staff, terminate the employee, and have Resident #1 assessed by psychiatric services.

The SA reviewed in-service sign in sheets that began on 7/27/23 related to abuse and misappropriation and the Administrator conducted one on one in-services in which she had every

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F 602	Continued From page 5 employee sign the policies abuse and vulnerable adult act. A record review of the "Behavioral Health Medication Recommendation", dated 8/1/23, revealed psychiatric services assessed the Resident #1 and made recommendations. On 8/14/23, the SA verified the facility reported the misappropriation to the SA and the AGO on 7/27/23. i	F 602		