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 04/11/2024

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 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 resident and staff interview, record review, and facility policy review, the facility failed to prevent abuse of a resident for one (1) of four (4) residents reviewed for abuse. Residents #25 Findings include: A review of the facility's "Abuse Policy and Procedure", undated, revealed, "Each resident of this facility has the right to be free from ...physical ...abuse ...Abuse is defined as the willful infliction of injury ...with resulting physical harm, pain or mental anguish ..." In an interview, on 04/10/24 at 10:00 AM, with Resident #25, he stated that on 04/09/24 on the 3-11 shift while being transferred from his wheelchair to his bed. He stated Certified Nurse Aide (CNA) #1 was "rough" with him. Resident #25 revealed the CNA positioned the lift sling	F 600	1. On April 10, 2024 Resident # 25 was assessed by the administrator, social services director, and Registered Nurse #1 for bruising, skin tears, and distress. The assessments revealed no signs of bruising, skin tears, or distress. 2. On April 10, 2024 It was determined by the administrator that all residents could be affected by this deficient practice. 3. On April 10, 2024 7 other residents were interviewed by the administrator and social services director and asked if they had experienced any abuse. On April 10, 2024, an In-service was conducted by the administrator for all staff on Abuse, Neglect, and Exploitation, and the Reporting of Abuse Neglect and Exploitation. All staff that were not in the	5/7/24

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

Electronically Signed | 04/18/2024

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F 600	Continued From page 1 underneath him and when she put the leg straps around his legs, she jerked up on them real hard. He stated that he told her that it hurts when she does that and the other nurse aides do not have to do it that way, but she did not respond to him. He admitted that he had not reported this to anyone. An interview on 04/10/24 at 3:15 PM, with Resident #25, revealed the Administrator and the Social Worker talked to him about the concern from 4/9/24. The resident stated that CNA #2 was also in the room when the incident occurred, but she was not rough with him, and she was always really nice. An interview on 04/10/24 at 3:25 PM, with CNA #2, confirmed that she was in the room when CNA #1 transferred Resident #25 from his wheelchair to his bed on 4/9/24. CNA #2 confirmed that CNA #1 was rough handling the resident. CNA #2 confirmed that when CNA #1 got the lift pad underneath the resident prior to the transfer, she snatched the straps in a rough manner and the resident told CNA #1 that it hurt, but she snatched the other leg strap the same way. CNA #2 admitted that she did not report this to anyone, but she knew she was supposed to. She said Resident #25 had begged her not to mention it to anyone. An interview on 04/10/24 at 3:30 PM, with the Administrator, confirmed Resident #25 reported the incident to him regarding CNA #1 and CNA #2. The Administrator stated that he interviewed CNA #2, and she confirmed that CNA #1 was rude and snappy with Resident #25 during the transfer on 04/09/24 but that she did not think it was abuse and that's why she did not report it to	F 600	building at the time of the in-service on April 10, 2024 will be in-serviced prior to working their next shift to be completed by April 30, 2024. In-services for all staff on Abuse, Neglect, and Exploitation, and the Reporting of Abuse, Neglect, and Exploitation will continue monthly for six months. 4. After in-services began on April 10, 2024, the administrator began monitoring on April 12, 2024 and will continue weekly times 3 weeks, then monthly times 3 months. Monitoring includes interviewing 4 cognitive residents, asking them about their care, and inquiring if any any abuse, neglect, or exploitation has taken place during their care. The data from monitoring will be discussed the Quality Assurance and Performance Improvement Plan committee meeting on April 30, 2024 times 3 months.	

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F 600	Continued From page 2 anyone. The Administrator revealed that he had reported the allegation to the State Agency (SA) and was continuing the investigation. The Administrator confirmed that both CNA #1 and CNA #2 were suspended pending the investigation. An interview on 4/11/24 at 10:46 AM, with CNA#1, she confirmed that she and CNA #2 transferred Resident #25 from the wheelchair to his bed using a mechanical lift. She denied that Resident #25 reported that she was hurting him during the transfer. A record review of a document titled "In-Service Training", revealed that both CNA #1 and CNA #2 received in-service training at the beginning of their scheduled shift on 04/09/24 regarding the facility's abuse policy, types of abuse, preventing abuse, neglect, exploitation and its definition, and Staff reporting policy. A record review of the "Admission Record" revealed the facility admitted Resident #25 on 1/5/22 with medical diagnoses that included Paraplegia. A review of the "BIMS (Brief Interview for Mental Status) assessment, dated 2/20/24, revealed Resident #25 had a BIMS score of 15, which indicated he was cognitively intact.	F 600		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:	F 609		5/7/24

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F 609	Continued From page 3 §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on resident and staff interview, record review and facility policy review the facility failed to report abuse in a timely manner for one (1) of four (4) residents reviewed for abuse. Residents #25 Findings include: A review of the facility's policy, "Staff Reporting," revised 3/21/22, revealed, "All employees of this facility must immediately report any incidents or suspected incident of resident... abuse... Any employee who has knowledge or reason to	F 609	1. On April 10, 2024 at 2:44pm, the incident was reported by the administrator to the state agency. 2. On April 10, 2024 It was determined by the administrator that all residents could be affected by this deficient practice. 3. On April 10, 2024, an In-service was conducted by the administrator for all staff on the timely reporting of Abuse, Neglect, and Exploitation. All staff that were not in the building at the time of the in-service	

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F 609	Continued From page 4 believe that a resident has been a victim of abuse is under a duty to immediately report such incident or suspicion to the charge nurse or administrator without fear of reprisal..." On 4/10/24 at 10:00 AM, in an interview with Resident #25, he stated that on 4/09/24 on the 3-11 shift, Certified Nurse Aide (CNA) #1 was rough with him during a transfer. He stated the CNA placed the sling underneath him and then she put the leg straps around his leg, and jerked on it hard, causing him pain. He stated he told the CNA that it hurt, and the other CNAs do not do it that way, but she did not respond to him. On 4/10/24 at 3:15 PM, Resident #25 stated the Administrator and Social Worker discussed the concern he had when CNA #1 was rough with him on 4/9/24. Resident #25 stated that CNA #2 was also in the room when the event occurred, but she was not rough with him and treated him nicely. On 4/10/24 at 3:25 PM, in an interview with CNA #2, she confirmed she was in the room when CNA #1 transferred Resident #25 from his wheelchair to his bed. CNA #2 confirmed that CNA #1 treated the resident roughly during the transfer by snatching the leg straps. She confirmed Resident #25 complained that it hurt, but CNA #1 snatched the other leg strap in the same rough manner. CNA #2 admitted that she did not report the abuse to anyone because Resident #25 did not want her to, but knew she was supposed to. She confirmed she was aware that abuse should be reported within two (2) hours. On 4/10/24 at 3:30 PM, in an interview with the	F 609	on April 10, 2024 will be in-serviced prior to working their next shift to be completed by April 30, 2024. In-services for all staff on the timely Reporting of Abuse, Neglect, and Exploitation will continue monthly for six months. 4. After in-services began on April 10, 2024, the administrator began monitoring on April 12, 2024 and will continue weekly times 3 weeks, then monthly times 3 months. Monitoring includes interviewing 4 cognitive residents, asking them about their care, and inquiring if any any abuse, neglect, or exploitation has taken place during their care. The data from monitoring will be discussed the Quality Assurance and Performance Improvement Plan committee meeting on April 30, 2024 times 3 months.	

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F 609	Continued From page 5	F 609		

Administrator, he confirmed Resident #25 reported the incident to him regarding CNA #1 and CNA #2. The Administrator stated that he interviewed CNA #2, and she confirmed that CNA #1 was rude and snappy with Resident #25 during the transfer on 4/09/24 but CNA #2 did not think that it was abuse and that was why she did not report it to anyone. The Administrator confirmed CNA #2 should have reported the abuse within two (2) hours of it occurring and he expected all staff to report abuse timely.

A record review of a document titled "In-Service Training", revealed that both CNA #1 and CNA #2 received in-service training at the beginning of their scheduled shift on 04/09/24 regarding the facility's abuse policy, types of abuse, preventing abuse, neglect, exploitation and its definition, and Staff reporting policy.

A record review of the "Admission Record" revealed the facility admitted Resident #25 on 1/5/22 with medical diagnoses that included Paraplegia.

A review of the "BIMS (Brief Interview for Mental Status) assessment, dated 2/20/24, revealed Resident #25 had a BIMS score of 15, which indicated he was cognitively intact.