STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255348	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/24/2025

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

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F0000	INITIAL COMMENTS The State Agency (SA) conducted an annual recertification survey at the facility from 7/21/25 through 7/24/25. During the survey, the SA determined the facility was not in compliance with the requirements of participation in Medicare and Medicaid and cited F684, F740, and F761. The facility had a census of 55 and was licensed for 60 beds.	F0000		08/04/2025
F0684 SS = D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is NOT MET as evidenced by: Based on interview, record review, and clinical judgment, the facility failed to ensure a resident received treatment and care in accordance with professional standards and physician orders to maintain or improve respiratory status. This failure was evidenced by not administering Albuterol Sulfate HFA (Hydrofluoroalkane) Inhalation Aerosol Solution 108 (90 Base) mcg/act (micrograms/actuation) as ordered for shortness of breath and/or wheezing. This deficient practice affected one (1) of (1) resident (Resident #11) reviewed for respiratory care. Findings Include: A review of the facility's policy, "Specific Medication Administration Procedures II B8 Oral Inhalation Administration," revised January 2018, revealed, "… Sequencing of inhaler medication: Bronchodilators are given first (example: albuterol), short-acting agents	F0684	1. On July 22, 2025, Resident # 11 was assessed by the Charge Nurse for any distress, shortness of breath, or other systems related to not receiving medications as ordered. 2. On July 22, 2025 it was determined by the Director of Nursing (DON) that any resident receiving scheduled and/or as needed (PRN) medications could be affected by this deficient practice. 3. On July 22, 2025, an in-service was conducted by the DON for all nurses on the Specific Medication Administration Procedures II B8 Oral Inhalation Administration Policy. License Practical Nurse (LPN) #1 was individually in-serviced. Staff will be in-serviced biweekly for one month on the Specific Medication Administration Procedures II B8 Oral Inhalation Administration Policy. 4. After in-services on July 22, 2025, the DON began monitoring on July 23, 2025. Monitoring includes interviewing two cognitive residents per hall that receive scheduled and/or PRN medication to ensure they have received all scheduled and PRN medications per policy. Monitoring will take place each week for six weeks. The data from monitoring will be discussed in the Quality Assurance and Performance Improvement Plan committee meeting on August 12, 2025 then monthly for one month.	08/13/2025

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F0684 SS = D	Continued from page 1 before long-acting agents." A record review of Resident #11's "Admission Record" revealed the facility admitted the resident on 6/24/25 with diagnoses including Chronic Diastolic Congestive Heart Failure and Essential (Primary) Hypertension. A record review of Resident #11's "Order Summary Report" with active orders as of 7/1/2025 revealed active prescriptions for Budesonide Inhalation Suspension 0.5 milligrams (mg)/2 mL(milliliters), to be inhaled orally twice daily for Chronic Obstructive Pulmonary Disease (COPD) (J44.9), and Albuterol Sulfate HFA Inhalation Aerosol Solution 108 mcg/act (90 mcg base), to be inhaled as two (2) puffs by mouth every four (4) hours as needed for shortness of breath (R06.02) and wheezing (R06.2). A record review of Resident #11's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 6/30/25 revealed a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident was cognitively intact. Section I6200 confirmed the presence of asthma or chronic lung disease. On 7/22/25 at 10:50 AM during an interview with Resident #11, she stated that on 7/19/25 and 7/20/25, she did not receive her inhalation medications as prescribed. Resident #11 reported she informed Licensed Practical Nurse (LPN) #1 that she had been receiving her inhaled medications in the same sequence for over three (3) years, specifically Albuterol Sulfate HFA prior to Budesonide Inhalation Suspension, and that this method was more effective in relieving her respiratory symptoms. Resident #11 stated that LPN #1 refused to administer the medications in the sequence she requested, and although the nurse checked on her several times, the Albuterol was withheld, contrary to the active physician order. On 7/22/25 at 3:50 PM, during an interview, the Director of Nursing (DON) stated he was contacted by the on-call nurse regarding the concern. The DON stated his reasoning for advising against giving Albuterol was based on a potential for tachycardia or increased heart rate with excessive beta-agonist use but acknowledged that there was no clinical assessment or documented justification to withhold the medication. He stated that if there was uncertainty about the medication regimen or sequencing, the provider should have been contacted for clarification. The DON acknowledged the medication was not administered as ordered. On 7/22/25 at 11:50 AM, during an interview, LPN #2	F0684		

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F0684 SS = D	Continued from page 2 stated she was the nurse on call when LPN #1 called with concerns about giving Albuterol with Budesonide. LPN #2 confirmed she contacted the DON, who instructed her that if the nurse was uncomfortable, she should withhold the medication. LPN #2 confirmed no clinical rationale was documented to justify withholding the medication. On 7/22/25 at 6:50 PM, during an interview, LPN #1 stated she was the assigned nurse for Resident #11 from 7/19/25 through 7/21/25. LPN #1 stated that the resident requested administration of Albuterol prior to Budesonide, but she was not comfortable doing so and therefore contacted the on-call nurse, who consulted the Director of Nursing (DON). LPN #1 stated she was advised that if she was uncomfortable, she should not administer the medication, and as a result, the Albuterol was not given. She further stated that she did not contact the prescribing provider for clarification, did not consult a drug reference guide or policy, and did not document any clinical justification for withholding the medication. She stated her primary concern was avoiding harm but could not explain a clinical reason for not administering the medication. On 7/23/25 at 11:08 AM, during an interview, the Nurse Practitioner confirmed that Resident #11 had active orders for Albuterol Sulfate HFA every four (4) hours as needed for shortness of breath/wheezing and Budesonide twice daily for COPD. She stated the orders are to be followed as written.	F0684		
F0740 SS = D	Behavioral Health Services CFR(s): 483.40 §483.40 Behavioral health services. Each resident must receive and the facility must provide the necessary behavioral health care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Behavioral health encompasses a resident's whole emotional and mental well-being, which includes, but is not limited to, the prevention and treatment of mental and substance use disorders. This REQUIREMENT is NOT MET as evidenced by: Based on interviews, record review and facility policy review, the facility failed to provide necessary care and services to assist a resident with a known	F0740	1. On July 24, 2025, Resident #9 was assessed by the Psychiatric Nurse Practitioner for psychosocial wellbeing. 2. On July 24, 2025 it was determined by the Director of Nursing (DON) that any resident that has lost a loved one could be affected by this deficient practice. 3. On July 24, 2025 an in-service was conducted by the DON for all nursing staff on the resident right to highest achievable physical, mental, and social wellbeing, as well as signs and symptoms of depression. Staff will be in-serviced biweekly for one month on the resident right to highest achievable physical, mental, and social wellbeing, as well as signs and symptoms of depression. 4. After assessment on July 24, 2025 by the psychiatric	08/13/2025

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F0740 SS = D	Continued from page 3 diagnosis of depression and anxiety in adjusting to a significant life stressor (bereavement) for one (1) of sixteen (16) sampled residents (Resident #9). Findings include: A record review of the policy " Dignity and Respect," no date, revealed, " You have the right to dignity and respect in the care you receive and the setting you live in. This includes the right...aims to reach or maintain for you the highest achievable level of physical, mental, and social well-being... On 7/21/2025 at 2:20 PM, during an initial interview, Resident #9 told SA that her son had recently died, and she needed to talk with someone about it. When asked if she had informed staff, she stated, “I have told every person who comes into my room.” When asked if she would like to speak with Social Services or a therapist, she responded, “Yes, one of them.” On 7/21/2025 at 2:27 PM, SA observed Certified Nursing Assistant (CNA) #1 outside Resident #9’s room. CNA #1 stated she provides care for Resident #9 and confirmed that since the resident's son passed away, every time she enters the room, the resident expresses a need to talk about it. CNA #1 stated she tries to talk about other things to help distract the resident. On 7/22/2025 at 10:01 AM, during a follow-up interview, Resident #9 told the State Agency (SA) that she needed prayer and support due to the recent death of her son. She reiterated her desire to speak with someone about her grief. On 7/22/2025 at approximately 12:45 PM, during an interview with the Social Service Director, she stated she was unaware if the contracted psychiatric provider had visited Resident #9 since her son’s death, adding that she had not scheduled a consultation. She confirmed the last visit occurred in June, prior to the resident’s loss. The Social Service Director added she would check with staff to see if anyone else had arranged a visit and reported that the resident had been placed on “bereavement watch,” the facility’s standard procedure following a resident’s loss. On 7/22/2025, at 1:18 PM, during an interview with Licensed Practical Nurse (LPN) #2 who is also the Medical Records Director, she stated that the contracted psychiatric service had not seen Resident #9 since June 24, 2025. She reported that there was no policy or procedure in place to support grieving residents other than placing them on bereavement watch,	F0740	Continued from page 3 nurse practitioner, the nurses began monitoring for signs of depression beyond the normal grieving process. Monitoring includes looking for signs of depression, resident interaction, and interviews daily for seven days then biweekly for four weeks. The contract behavioral company provided a social worker to speak with the resident on July 25, 2025 with follow ups scheduled three times per month for one month. The data from monitoring will be discussed in the Quality Assurance and Performance Improvement Plan Committee on August 12, 2025 then monthly for one month.	

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F0740 SS = D	Continued from page 4 which entails monitoring residents for behavioral changes. On 7/24/2025, at 8:01 AM, during an interview with the Director of Nursing (DON), he confirmed that the facility did not have a bereavement protocol beyond charting behaviors. He added that the Psychiatric Mental Health Nurse Practitioner (PMHNP) had last seen Resident #9 on June 24, 2025. He acknowledged a break in the process in this case regarding staff follow-up. On 7/24/2025 at 9:00 AM, during a follow-up interview with LPN #2, the SA inquired whether psychiatric services had been provided to Resident #9. LPN #1 stated she knew the PMHNP had been in the facility earlier that week but had not reviewed his notes. While the SA was present, LPN #1 called the PMHNP, who confirmed he was in the facility on July 23, 2025, but had not seen Resident #9 because he “did not have time.” He stated he would “try” to see her next time he came. Record review of the Psych (Psychiatric) Progress Note dated 6/24/25 revealed Resident #9 had been seen by the PMHNP and had the following presenting symptoms: Anxiety, Confused, Depressed/low mood and socially isolating. The active medical problem list included: Anxiety Disorder, Dementia, Depression, and Bipolar Disorder. A record review of the “Transfer/Discharge Report” revealed Resident #9 was admitted on 11/27/2024 with diagnoses including Depression and Anxiety Disorder. A review of the Minimum Data Set (MDS) assessment with an Assessment Reference Date (ARD) of 5/30/2025 revealed a Brief Interview for Mental Status (BIMS) score of 8, indicating moderate cognitive impairment.	F0740		
F0761 SS = D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals	F0761	1. On July 22, 2025, Resident # 16 was interviewed and assessed by the DON. Upon interview and assessment, the resident stated that she had not taken any TUMS or cough drops that day or the day prior, and showed no symptoms of having taken too much medication. The medications were immediately removed from the resident’s room. 2. On July 22, 2025 it was determined by the Director of Nursing (DON) that any resident that takes medication could be affected by this deficient practice.	08/13/2025

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F0761 SS = D	Continued from page 5 §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, record review, and facility policy review, the facility failed to ensure medications were securely stored and not accessible to residents for one (1) of 16 sampled residents, Resident #16. Findings include: A review of the facility's policy titled, "Medication Storage in the Facility," undated, revealed, "…Only licensed nurses, pharmacy personnel, and those lawfully authorized to administer medications (such as medication aides) are permitted to access medications. Medication rooms, carts, and medication supplies are locked when not attended by persons with authorized access." On 7/22/25 at 8:33 AM, during an observation of Resident #16's room, a bottle of TUMS and a bag of cough drops were noted in the resident's bedside basket. On 7/22/25 at 11:15 AM, during an observation and interview, the Director of Nursing (DON) accompanied the surveyor to Resident #16's bedside and confirmed that the TUMS and cough drops were present in the resident's room. On 7/22/25 at 11:30 AM, during an interview, the DON stated that medications are not to be stored at the bedside due to the risk of residents self-administering them, which can result in double dosing, drug interactions, or other potential harm. The DON stated the facility provides in-service training and conducts rounds to monitor medication storage. The DON reported that Resident #16 is legally blind, wanders, and has episodes of confusion, which makes her unable to safely	F0761	Continued from page 5 3. On July 22, 2025 an in-service was conducted by the administrator for all nursing staff and department heads on the Medication Storage Policy and items that are not allowed in resident rooms. Staff will be in-serviced biweekly for one month on Medication Storage Policy and items that are not allowed in resident rooms. Upon rounding rooms on July 22, 2025, department heads educated each resident of medications and other item that are not safe to store in resident rooms. On July 28, 2025 a letter was sent out to all Resident Representatives to educate on items that are not allowed to be stored in resident rooms. 4. After being in-serviced on July 22, 2025, department heads immediately rounded to all resident rooms to monitor for medications not properly stored. Monitoring includes rounding to all resident rooms, assessing all resident items, removing any items that are not allowed to be stored in resident rooms, and reporting back to the administrator weekly for seven weeks. The data from monitoring will be discussed in the Quality Assurance and Performance Improvement Plan committee meeting on August 12, 2025 then monthly for one month.	

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F0761 SS = D	Continued from page 6 self-administer medications. A record review of Resident #16's "Transfer/Discharge Report" revealed the facility admitted the resident on 6/27/25 with diagnoses including Essential (Primary) Hypertension. A record review of Resident #16's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 7/3/25 revealed a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident was cognitively intact.	F0761		