

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/29/2021
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255348	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 10/14/2020
NAME OF PROVIDER OR SUPPLIER TREND HEALTH & REHAB OF MERIDIAN LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 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 E000 A COVID-19 Focused Emergency Preparedness Survey was conducted by the Centers for Medicare & Medicaid Services (CMS) on 10/13-14/2020. The facility was found to be in compliance with 42 CFR §483.73 related to E-0024 (b)(6). The State Agency (SA) conducted a COVID-19 Focused Infection Control Survey and the Complaint Investigation (CI) # 16912 and CI #17119 on 10/13/20 to 10/14/20. The facility was found in compliance with infection control regulations and has implemented the recommended practices by CMS and Centers for Disease Control and Prevention (CDC) to prepare for COVID-19. During the investigation CI #16912 was not substantiated for concerns related to Quality of Care, Staffing, Neglect, Environmental concerns and staff screening for COVID-19. The CI #17119 was not substantiated for Physical Abuse. No deficiencies were cited. The census at the time of the survey was 44 with a license for 58 beds. During the survey, the SA requested information from the facility related to Infection Prevention Control Policy and Procedure (P&P) and Implementation Procedure, Emergency Preparedness Plan P&P and Implementation, Personal Protective Equipment (PPE) Availability, Staffing, Visitor Restriction, Positive COVID-19 Cases in facility, Hospital Transfers in past 14 Days with signs and symptoms (S/S) of Respiratory Distress, Reporting of positive COVID-19 cases of residents and staff. No concerns were noted during the review of the information.	F 000			
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE			TITLE		(X6) DATE

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.

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