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	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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. 39807 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 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. (continued on next page)

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.

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

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 04/11/2024
NAME OF PROVIDER OR SUPPLIER Trend Health & Rehab of Meridian LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 517 33rd Street Meridian, MS 39305	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 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.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 39807 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 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 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. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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.