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	07/24/2025

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. (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

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 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 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.

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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 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 [DATE] 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 [DATE] 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 [DATE] 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 [DATE] 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 [DATE], 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 [DATE]. She reported that there was no policy or procedure in place to support grieving residents other than placing them on bereavement watch, which entails monitoring residents for behavioral changes.On [DATE], 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 [DATE]. He acknowledged a break in the process in this case regarding staff follow-up.On [DATE] 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 [DATE], 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 [DATE] 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 [DATE] with diagnoses including Depression and Anxiety Disorder.A review of the Minimum Data Set (MDS) assessment with an Assessment Reference Date (ARD) of [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 8, indicating moderate cognitive impairment.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 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 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.