

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

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 09/10/2026	
NAME OF PROVIDER OR SUPPLIER TREND HEALTH & REHAB OF MERIDIAN LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 517 33RD STREET , MERIDIAN, Mississippi, 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
F0000	INITIAL COMMENTS The State Agency (SA) conducted an annual recertification survey at the facility from 09/8/26 through 09/10/26. During the survey, the SA determined the facility was not in compliance with the requirements of participation in Medicare and Medicaid and cited F565 and F698. The facility had a census of 54 and was licensed for 58 beds.			F0000			
F0565 SS = D	Resident/Family Group and Response CFR(s): 483.10(f)(5)(i)-(iv)(6)(7) §483.10(f)(5) The resident has a right to organize and participate in resident groups in the facility. (i) The facility must provide a resident or family group, if one exists, with private space; and take reasonable steps, with the approval of the group, to make residents and family members aware of upcoming meetings in a timely manner. (ii) Staff, visitors, or other guests may attend resident group or family group meetings only at the respective group's invitation. (iii) The facility must provide a designated staff person who is approved by the resident or family group and the facility and who is responsible for providing assistance and responding to written requests that result from group meetings. (iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility. (A) The facility must be able to demonstrate their response and rationale for such response. (B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group.			F0565			

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 reverse for further 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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F0565 SS = D	Continued from page 1 §483.10(f)(6) The resident has a right to participate in family groups. §483.10(f)(7) The resident has a right to have family member(s) or other resident representative(s) meet in the facility with the families or resident representative(s) of other residents in the facility. This REQUIREMENT is NOT MET as evidenced by: Based on interviews, record review and facility policy review, the facility failed to ensure residents' personal clothing was safeguarded and accounted for, resulting in ongoing concerns about missing items for two (2) of seven (7) Residents interviewed during the resident council meeting. Residents #18 and #21. Findings include: A policy review of the facility policy, "Resident Council Meetings" undated, revealed, "...Policy... 7. The facility shall act upon concerns and recommendations of the Council, make attempts to accommodate recommendations to the extent practicable and communicate its decision to the Council..." A record review of Resident Council meeting minutes revealed "missing clothing" for the following dates: 12/10/25, 4/8/26, 7/9/26, and 9/9/26. During the resident council meeting on 9/9/26 at 10:00 AM, multiple residents reported long-standing issues with missing clothing and stated they had not received resolution. Residents explained that when clothing was sent to the laundry, items frequently did not return. Resident #18 reported she was missing three blouses (peach, teal, and light blue) and a purple gown that were sent to laundry and never returned. She stated she informed the Social Service Director, the Laundry Supervisor, and the Administrator, and was told the items could not be located. She reported nothing was replaced and that she enjoyed wearing those items and wanted them returned. Resident #21 reported she was missing two shirts given to her by family during a trip to New York. She stated she did not report the missing items to staff because she believed they would not be replaced but said she would like the shirts replaced. During an interview at 10:34 AM, on 9/9/26, the Social Service Director revealed she was aware residents had been reporting missing clothing during council meetings for several months. She stated that if missing items cannot be found and are not listed on the resident's inventory sheet, the facility's policy is that they do not have to replace them,			F0565			

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F0565 SS = D	Continued from page 2 although the Administrator may choose to replace items on a case-by-case basis. At 4:31 PM on 9/9/26, in an interview, the Administrator acknowledged she was aware of ongoing concerns documented in council meeting minutes regarding missing clothing. She stated the facility had "failed" to put and maintain system in place for missing items and was still working to correct the issue. On 9/10/26 at 8:31 AM, the Activities Director reported that nearly every resident council meeting includes complaints of missing clothing. She stated she did not list specific resident names in the minutes because the concern is widespread among residents. She reported the issue dates back to 2025 and that a new process was recently implemented to address it. During a follow-up interview on 9/10/26 at 9:28 AM, the Administrator stated it is important for resident belongings to be accounted for because the facility is the residents' home and they should not have concerns about misplaced items. She reported the facility is putting systems in place to resolve the issue. At approximately 11:00 AM on 9/10/26, the Housekeeping Supervisor, hired in January 2026, acknowledged there has been an ongoing concern regarding missing resident clothing. She stated that beginning in July 2026, the facility implemented a system to address and resolve missing clothing concerns. Resident #21 A record review of the "Admission Record" revealed the facility admitted the Resident #21 on 10/27/20 with diagnosis including Essential (Primary) Hypertension. A record review of Resident #21 Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 6/30/26 revealed a Brief Interview for Mental Status (BIMS) score of (15) indicating Resident #21 is cognitively intact. Resident #18 A record review of the "Admission Record" revealed the facility admitted the Resident #18 on 2/4/22 with diagnosis including Obstructive Sleep Apnea. A record review of the Minimum Data Set (MDS) with	F0565					

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F0565 SS = D	Continued from page 3 an Assessment Reference Date (ARD) of 8/10/26 revealed a Brief Interview for Mental Status (BIMS) score of (15) indicating Resident #18 is cognitively intact.	F0565					
F0698 SS = D	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is NOT MET as evidenced by: Based on observations, resident and staff interviews, record review and facility policy review, the facility failed to implement and monitor a prescribed fluid restriction for one (1) of three (3) dialysis residents. (Resident #5). Findings include: Review of the facility's undated policy titled "Fluid Restriction" revealed, "Policy: Fluids will be restricted for residents as directed by physician orders...water pitchers will not be placed at bedside..." During an observation and interview on 09/08/2026 at 12:09 PM, Resident #5's lunch tray was observed on the bedside table along with a pitcher of ice water and a cup of coffee remaining from breakfast. The meal tray contained an eight-ounce glass approximately half-filled with water and an eight-ounce glass approximately half-filled with tea. Resident #5 stated the Certified Nursing Assistants (CNAs) filled the pitcher with ice water twice daily. Resident #5 confirmed being on a fluid restriction but stated he did not know the prescribed amount. Review of Resident #5's "Order Summary Report" revealed an order dated 7/23/26, "Renal diet, regular texture, regular liquids consistency, consistent-carbohydrate diabetic (CCD) renal, bedtime (HS) snack, 240 millimeters (ml) with each meal and 120 ml with 0800 and 2000 med pass." The prescribed fluid distribution totaled 960 ml daily. Review of Resident #5's Progress Note dated 05/08/2026 revealed, "called back to (proper name of dialysis facility) and spoke with nurse, (name).	F0698					

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F0698 SS = D	Continued from page 4 Stated resident is on an 1800 calorie (cal) American Diabetes Association (ADA) diet and 32 ounces/24 hours fluid restriction." Review of the Dietitian Progress Note undated and printed on 9/10/26 at 12:09 PM revealed, "...Resident receiving fluid restriction diet, regular texture and liquids with 240 cubic centimeter (cc) each meal and 120 cc with 0800 and 2000 med pass..." During an observation and interview on 09/10/2026 at 11:20 AM with Resident #5 and the Director of Nursing (DON), Resident #5 had a 22-ounce water pitcher and a coffee cup on the bedside table. He stated he received coffee and milk with breakfast and tea and water with lunch and dinner. He described the beverage glasses as approximately three-fourths full. Resident #5 also stated he sometimes requested coffee before bedtime. Record review of Resident #5's Medication Administration Records (MARs) for August and September 2026 revealed documented daily fluid intake exceeded the prescribed 960 ml fluid restriction on the following dates: 08/07/2026= 1,920 ml, 08/08/2026= 1,130 ml, 08/09/2026= 2,040 ml, 08/13/2026= 1,360 ml, 08/14/2026= 1,300 ml, 08/15/2026= 2,400 ml, 08/16/2026= 2,520 ml, 08/17/26= 1410 ml, 08/18/2026= 1,500 ml, 08/21/2026= 1,320 ml, 08/22/2026= 1,380 ml, 08/23/2026=1,800 ml, 08/25/2026= 1,160 ml, 08/27/2026= 1,320 ml, 08/30/2026= 2,080 ml, 09/02/2026= 1,200 ml, 09/03/2026= 1,260 ml, and 09/06/2026= 1,680 ml. During an interview on 09/10/2026 at 11:44 AM, the DON confirmed that fluid-intake documentation completed by nursing staff showed Resident #5's daily intake exceeded the prescribed daily allowance. The DON confirmed Resident #5 should not have had a water pitcher at the bedside because of the prescribed fluid restriction. The DON further confirmed Resident #5 was not typically noncompliant with the fluid restriction and did not have a care-planned problem or intervention addressing noncompliance. Record review of Resident #5's "Admission Record" revealed the resident was admitted to the facility on 5/8/26 with medical diagnoses that included Osteomyelitis of Vertebra, thoracic region and End Stage Renal Disease. Record review of Resident #5's Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 8/10/26, revealed a Brief Interview for Mental Status	F0698					

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F0698 SS = D	Continued from page 5 (BIMS) summary score of 15 under Section C, which indicated Resident #5 was cognitively intact.	F0698			