

MSDH - Health Facilities Licensure and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 40CH	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 10/22/2024
NAME OF PROVIDER OR SUPPLIER TREND HEALTH & REHAB OF CARTHAGE LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 1101 EAST FRANKLIN STREET CARTHAGE, MS 39051		
(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) COMPLETE DATE
M 000	Initial Comments The State Agency (SA) conducted two (2) complaint investigations (CI MS #26529 and CI MS #26656), at the facility on 10/22/2024. CI MS #26529 for alleged abuse of a resident; and CI MS #26656 for accidents and hazards. The SA determined that the facility was not in compliance with the Minimum Standards for Institutions for the Aged and Infirm, state licensure requirements for CI MS #26656 and deficiencies were cited at M500 and M640. The SA determined that the facility was not in compliance with CI MS #26529 and deficiencies were cited at M500. The facility was licensed for 83 beds and the census was 80 at the time of survey.	M 000		
M 500	45.17.2 Residents' Rights Residents' Rights. The residents' rights policies and procedures ensure that each resident admitted to the facility: 1. is fully informed, as evidenced by the resident's written acknowledgment, prior to or at the time of admission and during stay, of these rights and is given a statement of the facility's rules and regulations and an explanation of the resident's responsibility to obey all reasonable regulations of the facility and to respect the personal rights and private property of other residents; 2. is fully informed, and is given a written statement prior to or at time of admission and during stay, of services available in the facility, and of related charges including any charges for services covered by the facility's basic per diem rate; 3. is assured of adequate and appropriate	M 500		11/19/24

Mississippi State Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

11/08/24

MSDH - Health Facilities Licensure and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 40CH	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 10/22/2024
NAME OF PROVIDER OR SUPPLIER TREND HEALTH & REHAB OF CARTHAGE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 1101 EAST FRANKLIN STREET CARTHAGE, MS 39051		
(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) COMPLETE DATE
M 500	Continued From page 1 medical care, is fully informed by a physician or nurse practitioner/physician assistant of his medical conditions unless medically contraindicated (as documented by a physician or nurse practitioner/physician assistant in his medical record), is afforded the opportunity to participate in the planning of his medical treatment, to not be limited in his/her choice of a pharmacy or pharmacist provider in accordance with state law, as referenced in House Bill 1439, which states that the facility shall not limit a resident 's choice of pharmacy or pharmacy provider if that provider meets the same standards of dispensing guidelines required of long term care facilities, to refuse to participate in experimental research, and to refuse medication and treatment after fully informed of and understanding the consequences of such action; 4. is transferred or discharged only for medical reasons, or for his welfare or that of other residents, or for nonpayment for his stay (except as prohibited by sources of third-party payment), and is given a two weeks advance notice in writing to ensure orderly transfer or discharge. A copy of this notice is maintained in his medical record; 5. is encouraged and assisted, throughout his period of stay, to exercise his rights as a resident and as a citizen, and to this end may voice grievances, has a right of action for damages or other relief for deprivations or infringements of his right to adequate and proper treatment and care established by an applicable statute, rule, regulation or contract, and to recommend changes in policies and services to facility staff and/or to outside representatives of his choice, free from restraint, interference, coercion,	M 500			

MSDH - Health Facilities Licensure and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 40CH	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 10/22/2024
NAME OF PROVIDER OR SUPPLIER TREND HEALTH & REHAB OF CARTHAGE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 1101 EAST FRANKLIN STREET CARTHAGE, MS 39051		
(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) COMPLETE DATE
M 500	Continued From page 2 discrimination, or reprisal; 6. may manage his personal financial affairs, or is given at least a quarterly accounting of financial transactions made on his behalf should the facility accept his written delegation of this responsibility to the facility for any period of time in conformance with State law; 7. is free from mental and physical abuse; 8. is free from restraint except by order of a physician or nurse practitioner/physician assistant, or unless it is determined that the resident is a threat to himself or to others. Physical and chemical restraints shall be used for medical conditions that warrant the use of a restraint. Restraint is not to be used for discipline or staff convenience. The facility must have policies and procedures addressing the use and monitoring of restraint. A physician order for restraint must be countersigned within 24 hours of the emergency application of the restraint; 9. is assured security in storing personal possessions and confidential treatment of his personal and medical records, and may approve or refuse their release to any individual outside the facility, except, in the case of his transfer to another health care institution, or as required by law of third-party payment contract; 10. is treated with consideration, respect, and full recognition of his dignity and individuality, including privacy in treatment and in care for his personal needs; 11. is not required to perform services for the facility that are not included for therapeutic purposes in his plan of care;	M 500			

MSDH - Health Facilities Licensure and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 40CH	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 10/22/2024
NAME OF PROVIDER OR SUPPLIER TREND HEALTH & REHAB OF CARTHAGE LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 1101 EAST FRANKLIN STREET CARTHAGE, MS 39051		
(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) COMPLETE DATE
M 500	Continued From page 3 12. may associate and communicate privately with persons of his choice, may join with other residents or individuals within or outside of the facility to work for improvements in resident care, and send and receive his personal mail unopened, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 13. may meet with, and participate in activities of, social, religious and community groups at his discretion, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 14. may retain and use his personal clothing and possessions as space permits, unless to do so would infringe upon rights of other residents, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 15. if married, is assured privacy for visits by his/her spouse; if both are inpatients in the facility, they are permitted to share a room, unless medically contraindicated (as documented by the attending physician or nurse practitioner/physician assistant in the medical record); and 16. is assured of exercising his civil and religious liberties including the right to independent personal decisions and knowledge of available choice. The facility shall encourage and assist in the fullest exercise of these rights. This Statute is not met as evidenced by: Level III	M 500	1. Resident #1 was admitted to the	

MSDH - Health Facilities Licensure and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 40CH	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 10/22/2024
NAME OF PROVIDER OR SUPPLIER TREND HEALTH & REHAB OF CARTHAGE LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 1101 EAST FRANKLIN STREET CARTHAGE, MS 39051		
(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) COMPLETE DATE
M 500	Continued From page 4 Based on record review, observations, interviews, and facility policy review, the facility failed to ensure a resident's right to be free from abuse and neglect as evidenced by: 1) the facility failed to prevent verbal and physical abuse by a Certified Nursing Assistant (CNA) of Resident #2, and 2) failed to prevent neglect of a resident who required transfer via a mechanical lift (Resident #1), for two (2) of three (3) residents reviewed for abuse. Findings Include: Review of the facility policy titled, "Abuse Policy and Procedure," dated 04/02/24 and signed by CNA #6, revealed, "Each resident of this facility has the right to be free from verbal, sexual, physical and mental abuse ...neglect ..." Review of the facility policy and procedure titled "Code of Conduct" dated 04/02/24 and signed by CNA #6 revealed, "All employees must accept certain responsibilities, adhere to acceptable business practices in matters of conduct and behavior, and exhibit a high degree of personal integrity at all times." Review of the facility policy and procedure titled "Reporting Requirements of the Vulnerable Adult Act," dated 04/02/24 and signed by CNA #6 revealed. "Who is responsible for reporting? Any person who is employed at a care facility or is a health care professional working in connection with the facility who has knowledge or reasonable cause to believe that a resident of that care facility was the victim of abuse, neglect, or exploitation." Resident #2	M 500	hospital 10/02/2024. Resident #1 was discharged to the hospital on 10/17/2024 due to being past bed hold days. Certified Nursing Assistants (CNA) #2, #3, #4 and Licensed Practical nurse (LPN) #1 were inserviced regarding proper use of lift with transfers by the Director of Nursing (DON) on 10/03/2024. Follow up investigation done on 10/24/2024 by the Corporate Compliance Nurse (CCN) and it was determined that Certified Nurses Aides (CNA) #2 did use the mechanical lift for transfer of resident #1 without assistance of a second person and was terminated on 10/24/2024. Resident #2 was assessed by North Unit Manager (NUM) on 09/19/2024 and determined there were no injuries noted. CNA #6 was suspended on 09/19/2024 and terminated on 09/23/2024. 2. All residents have the potential to be affected by this deficient practice. 3. In-services on neglect and lift policy were began on 10/03/2024 by the DON and Staff Development Nurse (SDN) and will be completed on 11/11/2024 for all staff. The Administrator (ADM), the Administrator in Training (AIT), and the Assistant Director of Nursing (ADON) were in-serviced on 10/24/2024 by the CCN regarding proper investigation of incidents and / or allegations of neglect/abuse. The DON was in-serviced on 11/04/2024 by the CCN regarding proper investigation of incidents. On 10/24/2024 CNA #3, #4 and LPN #1 were educated verbally by CCN regarding only giving and writing statements that are	

MSDH - Health Facilities Licensure and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 40CH	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 10/22/2024
NAME OF PROVIDER OR SUPPLIER TREND HEALTH & REHAB OF CARTHAGE LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 1101 EAST FRANKLIN STREET CARTHAGE, MS 39051		
(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) COMPLETE DATE
M 500	Continued From page 5 Interview on 10/22/24 at 2:05 PM with CNA #5 she stated that she knew who CNA # 6 was but she had not really worked directly with her and didn't really know her, but when she saw her in the facility that she had an attitude. CNA #5 stated that about a month ago she was assisting Resident #3 with his bath when he confided in her that CNA #6 had been mean to his roommate (Resident #2). He stated that the privacy curtain had only been pulled halfway and he could see Resident #2 in his bed and he could see CNA #6 attempting to deliver care to the resident. CNA #6 was talking mean to Resident #2 and saying things like "Get your hands down and stop moving" as she slapped his hands and slapped the side of his face. Resident #3 stated that she mistreated Resident #2 and talked in a mean threatening voice to him. CNA #5 stated that she went to her Unit Manager Registered Nurse (RN) #1 and to the unit nurse Licensed Practical Nurse (LPN) #1 and reported the incidents of verbal and physical abuse. CNA #5 stated that Resident #3 was cognitive and gave good reliable statements to staff and verbalized reliable information and had good consistent memory recall. CNA #5 stated that Resident #3 had never varied with information when recalling the events of the incident of abuse by CNA #6 to his roommate Resident #2. CNA #5 stated that Resident #2 was looked after by the other residents and that he had been living at the facility for a long while and that he was Hispanic and did not speak English but could understand English language. CNA #5 stated that Resident #2 could answer questions by making physical gestures and nodding his head "Yes or "No." CNA #5 stated that the sister and family of Resident #2 visited him often and he would speak Spanish to his family and didn't really speak to anyone else. CNA #5 stated that	M 500	factual. CNA #2 was terminated on 10/24/2024. 4. All incidents and investigations will be reviewed beginning 10/24/2024 by the ADM or AIT before the process is closed. Beginning 10/24/2024 all reportable incidents will be reviewed by the ADM or AIT prior to submission to the local law enforcement agency, licensing/certification boards of the Attorney General's Office if required. Lift observations will be done for 3 residents, three time weekly x 3 weeks, then 3 transfers weekly x 2 months beginning 11/05/2024 by SDN to ensure that lifts are performed safely and per the care plan with two (2) persons as required. Findings of all monitoring inclusive of the investigations of incidents will be brought to the Quality Assurance (QA) Committee meeting by the ADM beginning 11/19/2024 and continue for three months for review to ensure that substantial compliance is being achieved.	

MSDH - Health Facilities Licensure and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 40CH	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 10/22/2024
NAME OF PROVIDER OR SUPPLIER TREND HEALTH & REHAB OF CARTHAGE LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 1101 EAST FRANKLIN STREET CARTHAGE, MS 39051		
(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) COMPLETE DATE
M 500	Continued From page 6 they had reported the abuse to the Director of Nursing (DON) and that she had requested that CNA #5 and RN#1 go together and talk to Resident #2 and Resident #3. CNA #5 stated that Resident #3 never changed his recall of the events of verbal and physical abuse of his roommate at the hands of CNA #6. Resident #3 stated that CNA #6 had slapped Resident #2 on the face and on his hands and had talked very "rudely and mean" to Resident #2. Interview on 10/22/24 at 2:25 PM, with the facility Administrator (ADM) revealed that she had been contacted by someone from outside the facility that CNA #6 had worked at another facility and that she had been terminated from that facility for the same type of abuse to residents. ADM stated that she pulled the employment application of CNA #6 to see if she had documented her employment at the other facility. The application did not contain the other facility as a place of employment, but CNA #6 had admitted during the investigation that she had been terminated at another facility, prior to current employment, for the "very same thing." ADM stated that the incident occurred on 09/19/24 and CNA #6 was sent home on suspension on 09/19/24 and was terminated on 09/23/24 for substantiated abuse of Resident #2. ADM stated that the facility staff believed what Resident #3 had reported and that he witnessed abuse of his roommate. Interview on 10/22/23 at 2:45 PM, with the Ombudsman confirmed that she had been given reports of verbal and physical abuse by CNA #6 at another facility prior to this report. Ombudsman stated that when she heard that CNA #6 had a second report of abuse at a second facility, she contacted her supervisor and her supervisor contacted the facility ADM. Ombudsman stated	M 500		

MSDH - Health Facilities Licensure and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 40CH	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 10/22/2024
NAME OF PROVIDER OR SUPPLIER TREND HEALTH & REHAB OF CARTHAGE LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 1101 EAST FRANKLIN STREET CARTHAGE, MS 39051		
(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) COMPLETE DATE
M 500	Continued From page 7 that she had many times spoken with Resident #3 and he was a very reliable witness. Interview on 10/22/24 at 12:05 PM, with CNA #1 stated that Resident #3 was cognitive, and he gave reliable information and he was not confused or demented. Interview on 10/22/24 at 5:19 PM, with RN #1 revealed that she had been instructed to go with CNA #5 and talk to Resident #3 and to Resident #2. RN #1 stated that Resident #3 told them that CNA #6 had verbally and physically abused Resident #2. Resident #3 stated that he saw CNA #6 slap the resident on the side of his face and on his hands. Resident #3 stated that he witnessed CNA #6 be "mean" and talk "mean" to Resident #2. RN #1 stated that they completed a physical assessment and did not find any injury to Resident #2. Resident #2 did not speak English, but he responded by demonstrating a slap to the side of his face. Resident #2 understands English but does not speak English. His sister came to the facility and Resident #2 told the sister that he had been slapped on the face and hands by CNA #6. RN #1 stated that she believed the reports of verbal and physical abuse given by Resident #2 and Resident #3. RN #1 confirmed that to her knowledge CNA #6 had been terminated from the facility for abuse of Resident #2. Interview on 10/22/24 at 5:50 PM, with CNA #6 via telephone revealed that "Yes" she had been terminated from the facility on 9/23/24 as a result of an alleged event of abuse toward Resident #2. CNA #6 denied the allegations of abuse and stated that she had worked at another facility and that she had left the other facility as a result of not passing the CNA exam in the time frame allotted by the facility. CNA stated that she received her	M 500		

MSDH - Health Facilities Licensure and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 40CH	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 10/22/2024
NAME OF PROVIDER OR SUPPLIER TREND HEALTH & REHAB OF CARTHAGE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 1101 EAST FRANKLIN STREET CARTHAGE, MS 39051		
(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) COMPLETE DATE
M 500	Continued From page 8 training at another facility, and she obtained her certification after she was terminated from that facility. CNA confirmed that she was placed on suspension on 09/19/24 and was terminated on 09/23/24 and stated that she was terminated for allegedly abusing Resident #2. Observation and interview on 10/22/24 at 6:00 PM, with Resident #3 confirmed that he had told CNA #5 that he witnessed CNA #6 verbally and physically abusing his roommate Resident #2. Resident #3 stated that the situation was now over and that CNA #6 was no longer working at the facility and he did not want to talk about it any more. Resident #3 stated that he had told CNA #6 to her face that "she knew she had abused (Resident #2) and it wasn't right." Resident #3 stated that he felt safe at the facility and he was not afraid or felt unsafe. Resident #3 stated that if he could have gotten up and walked over to his roommates bed during the time CNA #6 was abusing him that he would have taken care of things and she wouldn't do that any more. Resident #3 stated that his roommate was in "such bad shape and was unable to defend himself." It was observed to be approximately six (6) to eight (8) feet of distance between the bed of Resident #3 and the bed of Resident #2. Observation and interview with Resident #2 on 10/22/24 at 6:20 PM, revealed that he was sitting alone in the day room in a wheelchair sleeping. Resident #2 quickly opened his eyes when his name was called. The Resident did not attempt to verbalize but followed with his eyes as he was spoken to. He nodded his head "yes" and "no." He nodded "no" that he was not afraid, and he nodded "yes" that he was happy at the facility. Record review of a typed statement signed by the	M 500			

MSDH - Health Facilities Licensure and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 40CH	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 10/22/2024
NAME OF PROVIDER OR SUPPLIER TREND HEALTH & REHAB OF CARTHAGE LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 1101 EAST FRANKLIN STREET CARTHAGE, MS 39051		
(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) COMPLETE DATE
M 500	Continued From page 9 Psychiatric Mental Health Nurse Practitioner and dated 09/19/2024 revealed, "(Resident #2) sister asked him if someone had hit or slapped him, he indicated with a nod yes and rubbed his check with his hands. His sister asked him if he felt safe, he indicated with a nod no. His sister asked him if anyone had been mean to him he indicted with a nod yes. I spoke with (Resident #3) and he stated that he witnessed (CNA #6) physically hit (Resident #2) on the hand several times, push him over in the bed, and pull on him forcefully almost pulling him out of the bed and he says these types of behaviors have happened several times, however he could not give an approximate number. (Resident #3) states he told her don't be doing him like that and (CNA #6) response was "you shut up." Record review of a hand written statement signed by (CNA #5) dated 9/19/24 read: "On 9/19/2024 I (CNA #5) had gave (Resident #3) a shower. After his shower I was making up his bed he told me that his aid was super mean to him. So I asked him who he said the girl and the hallway they call her (name of CNA #6). So he was still telling me that she don't never do anything for him when he ask. Then he got talking about his roommate (Resident #2). He told me that she be hitting and slapping him when giving him a bath and the curtain be open so he see everything. He also said she almost snatched him out of bed one day and also pops his hand. So after leaving out the room I asked (LPN #1) the nursing what to do and (RN#1) was walking down the hall so I talk to both of them." Record review of the hand written statement of Resident #3 written by RN #1 and witnessed by CNA #5 dated 9/19/24 read: "(Resident #3) stated "The curtain was pulled half way but I	M 500		

MSDH - Health Facilities Licensure and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 40CH	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 10/22/2024
NAME OF PROVIDER OR SUPPLIER TREND HEALTH & REHAB OF CARTHAGE LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 1101 EAST FRANKLIN STREET CARTHAGE, MS 39051		
(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) COMPLETE DATE
M 500	Continued From page 10 could see. She was being rude and telling (Resident #2) , "Take your hands off me, don't touch me." (Resident #3) demonstrated to nurse (RN #1) and CNA (CNA #5) how CNA (CNA #6) slapped resident's hand. (Resident #3) stated, "she almost jerked him out of the damn bed and I told her not to jerk on him like that and she told me, oh just shut up." "She was slapping him on the hip telling (Resident #2) to turn over." "If I could have gotten up and walked, I would of gotten a hold of her." Written statement read back to (Resident #3) and he signed the statement that it was correct and his words. The statement was signed and witnessed by CNA #5 and RN#1 on 9/19/24. Record review of the facility's form titled: "NOTICE OF TERMINATION" documented that (CNA #6) date of hire 04/02/24 Position CNA Effective 9/23/2024 revealed that (CNA #6) had an involuntary termination from the facility for Rule Violation. Supervisor's Comments: "In light of the results of investigation into complaint/Grievance r/t (related to) Abuse of (Resident #2) and eyewitness account by his roommate Suspension 9/19/24 Termination 9/23/24 signed by ADM and DON and dated 9/23/24. Rehire NO." Record review of the Minimum Data Set (MDS) for Resident #3 dated 9/5/2024 revealed that he had a Brief Interview of Mental Status (BIMS) score of 14 indicating that he was cognitively intact. The record review of Resident #2's MDS Dated 7/19/2024 contained a BIMS score of 3 which indicated that Resident #2 was severely cognitively impaired.	M 500		

MSDH - Health Facilities Licensure and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 40CH	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 10/22/2024
NAME OF PROVIDER OR SUPPLIER TREND HEALTH & REHAB OF CARTHAGE LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 1101 EAST FRANKLIN STREET CARTHAGE, MS 39051		
(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) COMPLETE DATE
M 500	Continued From page 11 Resident #1 Cross reference F610, F656, F689 Record review of the Director of Nursing's (DON) investigation report dated October 2, 2024 and signed by the facility DON, stated, "Please find attached the investigation of the Right Intertrochanteric femoral fracture identified by CT with contrast on 10/02/24 at (Local Hospital) Emergency Room (ER). 10/02/24 this resident presented with black vomiting while at the nursing home. In light of the fall and head injury on 10/01/24 the Nurse Practitioner (NP) ordered transfer to (Local Hospital) ER via emergency medical services (EMS) for further evaluation." "On 10/02/24 ...the DON was notified of a possible Hip fracture noted on the initial abdominal x-ray. A second test, CT without contrast, was done ...identifying an acute comminuted and moderately displaced right hip fracture." The DON reported that on 10/02/24, after evaluation at the local ER, Resident #1 "was then transferred to (Another Hospital)." The DON's investigation report also documented "on 10/01/24 this resident, (Resident #1) had a fall from the lift sling during transfer bed to wheelchair in the resident's room at the nursing home. In attendance were 3 CNAs (CNA #4) (CNA #3) and (CNA #2) and a medication LPN, (LPN #1)." "As per the statements of the nurse and CNAs when they moved the lift to transfer to wheelchair the resident slid out of one side hitting head on the front of the wheelchair causing a skin tear on the forehead, the lift was lowered to the floor, resident was assessed, repositioned and lifted by the total lift back into the bed." "The NP and Resident Representative were notified. An order was received to transfer resident to the (Local Hospital) ER for evaluation. (Resident #1) was received back in the facility at 2220. The ER	M 500		

MSDH - Health Facilities Licensure and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 40CH	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 10/22/2024
NAME OF PROVIDER OR SUPPLIER TREND HEALTH & REHAB OF CARTHAGE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 1101 EAST FRANKLIN STREET CARTHAGE, MS 39051		
(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) COMPLETE DATE
M 500	Continued From page 12 identified only the forehead skin tear." Interview on 10/22/24 at 11:50 AM with Certified Nursing Assistant (CNA) #1 revealed that she trained all the CNA's on the use of all mechanical lifts. She stated that the facility required two (2) person's to assist with the mechanical lifting of all residents. CNA #1 stated that "Especially because of the resident's size there would be a necessity to use at least two (2) staff, and maybe more, while using the mechanical lift." CNA #1 confirmed that two staff must assist "hands-on" when using a mechanical lift for all facility residents. CNA #1 stated that both of the two assisting staff should be holding on to the lift and/or holding on to the resident during the entire mechanical lifting process. She stated that two staff should assist with placing the sling under the resident and two staff were required to hook the sling to the lift and check the accurate attachment of the sling to the lift; and two staff are required to be holding on to the resident and making sure the transfer was steady; by holding on to the resident from the time of sling placement, until the resident is safely and securely transferred would provide safety and assurance of a mechanical lift transfer. CNA #1 stated that never during the mechanical lift process of a resident should there be one (1) staff transferring a resident with a mechanical lift. CNA #1 stated that the use of one (1) staff using a mechanical lift was not in accordance with the facility policy and procedure. Interview on 10/22/24 at 12:20 PM with Licensed Practical Nurse (LPN) #1 via (by) telephone revealed that she was called to the room of Resident #1 to watch CNA #2 to operate the mechanical lift and transfer Resident #1 from the bed to the wheelchair. LPN #1 stated that she was called there to "spot" CNA #2 as she used	M 500			

MSDH - Health Facilities Licensure and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 40CH	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 10/22/2024
NAME OF PROVIDER OR SUPPLIER TREND HEALTH & REHAB OF CARTHAGE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 1101 EAST FRANKLIN STREET CARTHAGE, MS 39051		
(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) COMPLETE DATE
M 500	Continued From page 13 the lift to transfer Resident #1. LPN #1 stated that "spot" meant to watch her use the mechanical lift, that she did not assist CNA #2 with the operation of the lift for Resident #1 and that she did not have her hands on the lift or her hands on Resident #1 during the transfer with the mechanical lift. LPN #1 stated that when she entered the room she saw CNA #2 operating the mechanical lift and that Resident #1 was up in the air in the sling when the mechanical lift tilted and Resident #1 fell to the floor. LPN #1 stated that CNA #4 was standing behind her near the door of Resident #1's room. LPN #1 stated that there was another CNA assisting CNA #2 with the mechanical lift but she did not know her name and she was unable to recall who the third CNA was that was there to assist. LPN #1 stated that Resident #1 fell from the lift and hit her head and received a skin tear. LPN #1 stated that she assessed Resident #1 while she was on the floor. Three (3) CNA's and LPN #1 assisted to lift Resident #1 back to the bed and LPN #1 stated that she assessed Resident #1 again while she was in the bed. LPN #1 stated that Resident #1 was bleeding from the injury to her forehead and she placed a compression bandage to the bleeding area of Resident #1's head. LPN #1 obtained orders to send Resident #1 to the ER for evaluation. Resident #1 left the facility via ambulance at approximately 9:00 AM on 10/01/24 and was returned to the facility at approximately 3:00 P.M. on 10/01/24 at change of shift. Resident #1 returned from the ER with a diagnosis of a skin tear to her forehead. LPN #1 stated that there was no misuse of the mechanical lift and that there were two (2) CNA's assisting with the mechanical lift of Resident #1. LPN #1 was not able to recall or describe who the second CNA was that assisted CNA #2 to operate the mechanical lift.	M 500			

MSDH - Health Facilities Licensure and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 40CH	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 10/22/2024
NAME OF PROVIDER OR SUPPLIER TREND HEALTH & REHAB OF CARTHAGE LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 1101 EAST FRANKLIN STREET CARTHAGE, MS 39051		
(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) COMPLETE DATE
M 500	Continued From page 14 Interview via telephone on 10/22/24 at 12:30 PM, with CNA #4 revealed that she was asked by LPN #1 to come with her to Resident #1's room. CNA #4 stated that when she entered the room of Resident #1, she saw the resident up in the air in the sling then she turned around to close the room door behind her and when she turned back around Resident #1 had fallen to the floor from the sling. CNA #4 stated that she did not see Resident #1 fall and she does not know who the other CNA was assisting CNA #2 with the mechanical lift, did not know her name and did not pay attention to what she looked like because she was concentrating on the resident. CNA #4 stated that she assisted the LPN #1 and the other two (2) CNAs to lift Resident #1 back to her bed after the fall. CNA #4 stated that Resident #1 obtained a skin tear to her head and was bleeding at her forehead. CNA #4 stated that LPN #1 assessed Resident #1 and placed a bandage on her bleeding head. CNA #4 stated that she did not assist with the operation of the mechanical lift, and she did not have her hands on the lift or on Resident #1 during the bed to wheelchair transfer. CNA #4 stated that she was in the room when Resident #1 fell but she did not see her fall because she was closing the door to the room behind her. She stated that she does not know how the incident occurred. Interview on 10/22/24 at 12:36 PM, with CNA #2 revealed that she had given Resident #1 a bed bath on the morning of 10/01/24 at approximately 8:30 AM just after the breakfast meal. CNA #2 stated that she was very nervous to give an interview and would probably get things confused because she was so nervous. CNA #2 was tearful and shaky during the entire interview. CNA #2 verbalized that she loved the residents and	M 500		

MSDH - Health Facilities Licensure and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 40CH	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 10/22/2024
NAME OF PROVIDER OR SUPPLIER TREND HEALTH & REHAB OF CARTHAGE LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 1101 EAST FRANKLIN STREET CARTHAGE, MS 39051		
(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) COMPLETE DATE
M 500	Continued From page 15 needed her job and that she would not intentionally do anything to hurt a resident. She repeatedly verbalized "it's on me, I should not have started doing the lift before CNA #3 entered the room to help me." CNA #2 stated that she had solely given Resident #1 a bed bath and placed the sling under Resident #1 and had independently attached the sling to the lift and had lifted Resident #1 up above the bed prior to CNA #3 entering the room. CNA #2 stated that CNA #3 did come into the room after she had lifted Resident #1 up above the bed in the mechanical lift. CNA #2 stated she sees now that she should have waited until CNA #3 was present in the room before she started operating the mechanical lift. CNA #2 stated that CNA #3 was standing behind the wheelchair as she was lifting Resident #1. CNA #1 stated that she was driving the lift and when she had Resident #1 up in the air the mechanical lift tilted, and Resident #1 fell out and hit her head. She stated that LPN #1 and CNA #4 were also in the room watching her lift Resident #1. CNA #2 confirmed that there was no staff holding on to Resident #1 while she was lifting Resident #1 from the bed to the wheelchair. CNA #2 stated that Resident #1 fell out of the lift and hit her head and she began to bleed. She stated that LPN #1 told CNA #2 to continue to lower Resident #1 to the floor so they could assess her and treat her bleeding head. LPN #1 assessed Resident #1 while she was on the floor and then all four (4) of the staff (CNA #2, CNA #3, CNA #4 and LPN #1) assisted to transfer Resident #1 from the floor back into the bed, where LPN #1 re-assessed Resident #1 while she was in the bed. Resident #1 was transported to the hospital with a head injury on 10/01/24 at approximately 9:00 A.M. Interview on 10/22/24 at 1:30 PM, with CNA #3	M 500		

MSDH - Health Facilities Licensure and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 40CH	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 10/22/2024
NAME OF PROVIDER OR SUPPLIER TREND HEALTH & REHAB OF CARTHAGE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 1101 EAST FRANKLIN STREET CARTHAGE, MS 39051		
(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) COMPLETE DATE
M 500	Continued From page 16 revealed that she was not in the room with CNA #2 when she used the mechanical lift to transfer Resident #1. CNA #3 stated that she was with another resident assisting with her breakfast when (CNA #2) came and got her to help with Resident #1. CNA #2 stated that upon entering Resident #1's room there were no other staff present and Resident #1 was on the floor bleeding from the forehead. CNA #3 stated that CNA #2 had used the mechanical lift alone without a second staff and Resident #1 had fallen and received a head injury. They called LPN #1 and CNA #4 came along with LPN #1 to help get Resident #1 up off of the floor and back into the bed. The four (4) staff together assisted Resident #1 back to her bed where the LPN #1 assessed the resident. CNA #3 confirmed that she had provided a handwritten statement to the facility Director of Nursing (DON) confirming that she was not in the room when Resident #1 fell from the lift. CNA #3 reviewed her handwritten statement with the State Agency (SA) and confirmed that was her statement that was given to the DON. CNA #3 verbalized that Resident #1 was a large lady and that she required at least two (2) persons to assist with her care and to steady the mechanical lift. CNA #3 stated that Resident #1 never moved and was unable to move or wiggle because she was physically disabled. CNA #3 again confirmed that she was not in the room when CNA #2 was utilizing the lift and that she had told the DON that in her statement. Interview on 10/22/24 at 2:25 PM, with the facility Assistant Director of Nursing (ADON) and the ADM revealed that all mechanical lifts required two (2) persons to assist with the operation of the lift and the resident. Both the ADON and the ADM confirmed that they were not aware that CNA #2	M 500			

MSDH - Health Facilities Licensure and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 40CH	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 10/22/2024
NAME OF PROVIDER OR SUPPLIER TREND HEALTH & REHAB OF CARTHAGE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 1101 EAST FRANKLIN STREET CARTHAGE, MS 39051		
(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) COMPLETE DATE
M 500	Continued From page 17 had transferred Resident #1 with the lift by herself. Both the ADON and the ADM expressed that they were under the impression that the DON had thoroughly investigated the incident and had determined that there were three (3) staff assisting CNA #2 with the mechanical lift. "Not until today were we made aware that the incident happened another way," stated the ADM. The ADM stated that on 10/02/24 Resident #1 was sent from the local ER for a hip fracture and had never returned to the facility and had been discharged from the facility. The ADM stated that she would talk to the DON when she returned to the facility from medical leave. The ADM confirmed that the incident should have been thoroughly investigated and that she should have known because she is ultimately the one who signs off on allegations of abuse or neglect, but she was unaware. Record review of the hand written statement that was provided to the DON on 10/03/24 by CNA #3 stated, "On October 1, 2024 I was walking to feed a resident, as I was alerted to come in (Resident #1's) room. Once I walked into the room she was already laying on the floor. The nurse examined her. Then me, nurse, and another aide proceeded to help get her up off the floor and put back into the bed." The hand written statement was signed by CNA #3 and dated 10/3/2024. Record review of the hand written statement that was provided to the DON on 10/1/24 and signed by (CNA #4) stated, "As me, (CNA #3), and (LPN#1) was walking in the room she began to lifted (Resident #1) as she was lifting she slipped out the sling hit her head on the wheel of the wheel chair the rooms are so cluttered where you can't move around without hitting things in the room."	M 500			

MSDH - Health Facilities Licensure and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 40CH	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 10/22/2024
NAME OF PROVIDER OR SUPPLIER TREND HEALTH & REHAB OF CARTHAGE LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 1101 EAST FRANKLIN STREET CARTHAGE, MS 39051		
(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) COMPLETE DATE
M 500	Continued From page 18 Record review of the hand written statement that was provided to the DON on 10/3/24 by CNA #2 stated, "I (CNA #2) gave (Resident #1) a bedbath for shower Day; got her fully dressed to get up. I made sure she was pulled up in bed before stepping out. Went to shower room and grab the total lift and brought into room, had her chair by bed being prepared to get her up. I went to door to ask someone to spot me with lift So (LPN #1) (the nurse) and two CNA came behind her as I was proceeding to transfer her to put in chair. The total lift tilted over and (Resident #1) fell and Hit her head on the edge of her chair leg." The hand written statement was signed by CNA #2 and dated 10/3/24. Record review of the undated hand written statement provided to the DON by LPN #1 stated, "I was asked to step in the room to assist with a total transfer, along with 2 other staff. Once I stepped into the room. Staff began to lift her off the bed. Once lifted she steered the lift to get her over the wheelchair. As she began to steer the lift, resident slipped out of sling hitting her head on the front of wheelchair." Record review of "After Visit Summary", dated 10/01/24, from the hospital stated, "Tylenol only for pain. Monitor wound for any development of infection. Return for vomiting, weakness, lethargy." "Reason for visit: Fall ...Laceration of forehead ..." Record review of Hospital ER report dated 10/02/24 and titled, "CT Abdomen Pelvis with contrast," revealed "Reason for visit n/v (nausea and vomiting)" "Results: Acute appearing right femoral intertrochanteric fracture."	M 500		

MSDH - Health Facilities Licensure and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 40CH	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 10/22/2024
NAME OF PROVIDER OR SUPPLIER TREND HEALTH & REHAB OF CARTHAGE LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 1101 EAST FRANKLIN STREET CARTHAGE, MS 39051		
(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) COMPLETE DATE
M 500	Continued From page 19 The record review of the investigation completed by the facility's DON was not consistent with the handwritten statements of the CNAs nor the LPN's handwritten statement. On 10/25/24, after the SA had exited the survey, the facility's ADON notified via email and confirmed that they had re-interviewed and the CNA's and LPN involved with the incident of Resident #1's fall from the mechanical lift and that CNA #2 CNA #4 and LPN #1 confessed that they had not been truthful and had lied on their original statements that they gave to the DON on 10/1/24-10/3/24. CNA #2 confessed that she used the mechanical lift alone and improperly and that the other three (3) CNA's were not in the room when the fall of Resident #1 occurred. LPN #1 and CNA #4 both gave new statements that they were not present in the room with CNA #2 when Resident #1 fell and received serious injury and that they had falsified their statements and had not been truthful during the investigation of the suspected neglect. The record review of the Admission Record of Resident #1 revealed that she was admitted to the facility on 11/22/2022 with diagnosis of Cerebral Infarction Due to Embolism of left middle cerebral artery; among many other diagnoses. Record review of the Section C of the Minimum Data Set (MDS) dated 09/12/2024 for Resident #1 revealed she was severely cognitively impaired.	M 500		
M 640	45.21.8 Accidents Accidents. The facility shall ensure that the residents ' environment remains as free of accident hazards as possible, and adequate	M 640		11/19/24

MSDH - Health Facilities Licensure and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 40CH	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 10/22/2024
NAME OF PROVIDER OR SUPPLIER TREND HEALTH & REHAB OF CARTHAGE LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 1101 EAST FRANKLIN STREET CARTHAGE, MS 39051		
(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) COMPLETE DATE
M 640	Continued From page 20 supervision shall be provided to prevent accidents. If an unexplained accident occurs, this injury must be investigated and reported to appropriate state agencies. This Statute is not met as evidenced by: Level III Based on observation, interviews, record reviews, and facility policy and procedures review the facility failed to avoid a preventable accident when Resident #1 was transferred with a mechanical lift without the required two (2) person transfer assistance. This resulted in Resident #1 sustaining an injury to her forehead and a right intertrochanteric femoral fracture requiring surgery. Resident #1 was transported to the hospital Emergency Room (ER) two times related to the accident. This was for one (1) of three (3) residents reviewed. Resident #1 Findings Included: Review of the facility policy, undated, titled: "Modified Lifting Policy" read: "PROCEDURE: 1. Use of a mechanical lift requires two (2) nursing assistants to perform the procedure each time that it is used. 2. Staff will follow the documented lifting protocol deemed appropriate for each resident. This information is documented in the resident's chart and via a sticker system in a designated area of the facility for reference to each resident. This information should be referred to prior to lifting/transferring or assisting each resident. This documentation will also include type of lift and sling determined to be appropriate for each resident..."	M 640	1. Resident #1 had follow up investigation on 10/24/2024 by the Corporate Compliance Nurse (CCN) and it was determined that Certified Nurses Aides (CNA) #2 did use the mechanical lift for transfer of resident #1 without a second person. CNA #2, #3, #4 and Licensed Practical Nurse (LPN) #1 were in-serviced regarding use of lift with transfers by the Director of Nursing (DON) on 10/03/2024. Resident #1 was admitted to the hospital on 10/02/2024 and discharged to the hospital on 10/17/2024 due to being past bed hold days. CNA #2 was terminated on 10/24/2024 after follow up investigation. 2. All residents have the potential to be affected by this deficient practice. 3. In-services on neglect and lift policy were began on 10/03/2024 by the DON and Staff Development Nurse (SDN) and will be completed on 11/11/2024 for all staff. The Administrator (ADM), the Administrator in Training (AIT), and the Assistant Director of Nursing (ADON) were in-serviced on 10/24/2024 by the CCN regarding proper investigation of incidents and / or allegations of neglect/abuse. The DON was in-serviced on 11/04/2024 by the CCN regarding proper investigation of incidents. On 10/24/2024, CNA #3, #4 and LPN #1 were	

MSDH - Health Facilities Licensure and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 40CH	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 10/22/2024
NAME OF PROVIDER OR SUPPLIER TREND HEALTH & REHAB OF CARTHAGE LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 1101 EAST FRANKLIN STREET CARTHAGE, MS 39051		
(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) COMPLETE DATE
M 640	Continued From page 21 The facility provided a notice that was posted in the facility that read: "WARNING! Nursing Staff Never Use a Lift Alone! It is ABUSE! THE FACILITY POLICY IN REGARDS TO LIFTING WITH A MECHANICAL LIFT IS 1. Two Person Assist Every Time a Lift is Used 2. Properly apply the Sling 3. Always Assure you are using the correct lift." Record review of the DON's investigation report dated October 2, 2024 and signed by the facility DON, stated, "Please find attached the investigation of the Right Intertrochanteric femoral fracture identified by CT with contrast on 10/02/24 at (Local Hospital) ER. 10/02/24 this resident presented with black vomiting while at the nursing home. In light of the fall and head injury on 10/01/24 the Nurse Practitioner (NP) ordered transfer to (Local Hospital) ER via EMS for further evaluation." "On 10/02/24 ...the DON was notified of a possible Hip fracture noted on the initial abdominal x-ray. A second test, CT without contrast, was done ...identifying an acute comminuted and moderately displaced right hip fracture." The DON reported that on 10/02/24, after evaluation at the local ER, Resident #1 "was then transferred to (Another Hospital)." The DON's investigation report also documented "on 10/01/24 this resident, (Resident #1) had a fall from the lift sling during transfer bed to wheelchair in the resident's room at the nursing home. In attendance were 3 CNAs (CNA #4) (CNA #3) and (CNA #2) and a medication LPN, (Licensed Practical Nurse #1)." "As per the statements of the nurse and CNAs when they moved the lift to transfer to wheelchair the resident slid out of one side hitting head on the front of the wheelchair causing a skin tear on the forehead, the lift was lowered to the floor, resident was assessed, repositioned and lifted by	M 640	verbally educated regarding only giving and writing statements that are factual. CNA #2 was terminated 10/24/2024. 4. All incidents and investigations, beginning 10/24/2024, will be reviewed by the ADM or AIT before the process is closed. Beginning 10/24/2024, all reportable incidents will be reviewed by the ADM or AIT prior to submission to the local law enforcement agency, licensing/certification boards of the Attorney General's Office if required. Lift observations will be done for 3 residents, three time weekly x 3 weeks, then 3 transfers weekly x 2 months beginning 11/05/2024 by SDN to ensure that lifts are performed safely and per the care plan with two (2) persons as required. Findings of all monitoring inclusive of the investigations of incidents will be brought to the Quality Assurance (QA) Committee meeting by the ADM beginning 11/19/2024 and continue for three months for review to ensure that substantial compliance is being achieved.	

MSDH - Health Facilities Licensure and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 40CH	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 10/22/2024
NAME OF PROVIDER OR SUPPLIER TREND HEALTH & REHAB OF CARTHAGE LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 1101 EAST FRANKLIN STREET CARTHAGE, MS 39051		
(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) COMPLETE DATE
M 640	Continued From page 22 the total lift back into the bed." "The NP and Resident Representative were notified. An order was received to transfer resident to the (Local Hospital) ER for evaluation. (Resident #1) was received back in the facility at 2220. The ER identified only the forehead skin tear." On 10/22/24 at 11:50 AM, in an interview with Certified Nursing Assistant (CNA) #1 revealed that she trained all the CNA's on the use of all mechanical lifts. She stated that the facility required two (2) person's to assist with the mechanical lifting of all residents. CNA #1 stated that the only way that a resident could possibly fall from a mechanical lift would be due to improper use of the lift or by placing the wrong size sling to the lift to move a resident. CNA #1 stated that she did not witness the fall of Resident #1, but stated that she had in past times assisted with the transfer of the resident and that she never moved about while in the lift because of her severely compromised physical and mental condition and was incapable of movement. CNA #1 stated that Resident #1 was non verbal and was dependent upon staff for all of her needs. CNA #1 stated that "Especially because of the resident's size there would be a necessity to use at least two (2) staff, and maybe more, while using the mechanical lift." CNA #1 confirmed that two staff must assist "hands-on" when using a mechanical lift for all facility residents. CNA #1 stated that never during the mechanical lift process of a resident should there be one (1) staff transferring a resident with a mechanical lift. CNA #1 stated that the use of one (1) staff using a mechanical lift was not in accordance with the facility policy and procedure. On 10/22/24 at 12:20 PM, interview with Licensed Practical Nurse (LPN) #1 via (by) telephone	M 640		

MSDH - Health Facilities Licensure and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 40CH	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 10/22/2024
NAME OF PROVIDER OR SUPPLIER TREND HEALTH & REHAB OF CARTHAGE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 1101 EAST FRANKLIN STREET CARTHAGE, MS 39051		
(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) COMPLETE DATE
M 640	Continued From page 23 revealed that she was called to the room of Resident #1 to watch CNA #2 to operate the mechanical lift and transfer Resident #1 from the bed to the wheelchair. LPN #1 stated that she was called there to "spot" CNA #2 as she used the lift to transfer Resident #1. LPN #1 stated that "spot" meant to watch her use the mechanical lift, that she did not assist CNA #2 with the operation of the lift for Resident #1 and that she did not have her hands on the lift or her hands on Resident #1 during the transfer with the mechanical lift. LPN #1 stated that when she entered the room she saw CNA #2 operating the mechanical lift and that Resident #1 was up in the air in the sling when the mechanical lift tilted and Resident #1 fell to the floor. LPN #1 stated that CNA #4 was standing behind her near the door of Resident #1's room. LPN #1 stated that there was another CNA assisting CNA #2 with the mechanical lift but she did not know her name and she was unable to recall who the third CNA was that was there to assist. LPN #1 stated that Resident #1 fell from the lift and hit her head and received a skin tear. LPN #1 stated that she assessed Resident #1 while she was on the floor. Three (3) CNA's and LPN #1 assisted to lift Resident #1 back to the bed. LPN #1 stated that she assessed Resident #1 again while she was in the bed. LPN #1 stated that Resident #1 was bleeding from the injury to her forehead and she placed a compression bandage to the bleeding area of Resident #1's head. LPN #1 obtained orders to send Resident #1 to the ER for evaluation. Resident #1 returned from the ER with a diagnosis of a skin tear to her forehead. LPN #1 stated that there was no misuse of the mechanical lift and that there were two (2) CNA's assisting with the mechanical lift of Resident #1. LPN #1 was not able to recall or describe who the second CNA was that assisted CNA #2 to operate	M 640			

MSDH - Health Facilities Licensure and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 40CH	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 10/22/2024
NAME OF PROVIDER OR SUPPLIER TREND HEALTH & REHAB OF CARTHAGE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 1101 EAST FRANKLIN STREET CARTHAGE, MS 39051		
(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) COMPLETE DATE
M 640	Continued From page 24 the mechanical lift. On 10/22/24 at 12:30 PM, during a telephone interview with CNA #4 revealed that she was asked by LPN #1 to come with her to Resident #1's room. CNA #4 stated that when she entered the room of Resident #1 she saw the resident up in the air in the sling then she turned around to close the room door behind her and when she turned back around Resident #1 had fallen to the floor from the sling. CNA #4 stated that she did not see Resident #1 fall. CNA #4 stated that she did not know the name of the CNA that was assisting CNA #2 and did not pay attention to what she looked like because she was concentrating on the resident. CNA #4 stated that she assisted LPN #1 and the other two (2) CNA's to lift Resident #1 back to her bed after the fall. CNA #4 stated that Resident #1 obtained a skin tear to her head and was bleeding at her forehead. CNA #4 stated that LPN #1 assessed Resident #1 and placed a bandage on her bleeding head. She stated that she does not know how the incident occurred. On 10/22/24 at 12:36 PM, during an interview with CNA #2 revealed that she had given Resident #1 a bed bath on the morning of 10/01/24. CNA #2 stated that she was very nervous to give an interview and would probably get things confused because she was so nervous. CNA #2 was tearful and shaky during the entire interview. CNA #2 verbalized that she loved the residents and needed her job and that she would not intentionally do anything to hurt a resident. She repeatedly verbalized numerous times "it's on me, I should not have started doing the lift before CNA #3 entered the room to help me." CNA #2 stated that she had solely given Resident #1 a bed bath and had placed the sling	M 640			

MSDH - Health Facilities Licensure and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 40CH	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 10/22/2024
NAME OF PROVIDER OR SUPPLIER TREND HEALTH & REHAB OF CARTHAGE LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 1101 EAST FRANKLIN STREET CARTHAGE, MS 39051		
(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) COMPLETE DATE
M 640	Continued From page 25 under Resident #1 and had independently attached the sling to the lift and had lifted Resident up above the bed prior to CNA #3 entering the room. CNA #2 stated she sees now that she should have waited until CNA #3 was present in the room before she started operating the mechanical lift. CNA #2 stated that CNA #3 was standing behind the wheelchair as she was lifting Resident #1. CNA #1 stated that she was driving the lift and when she had Resident #1 up in the air the mechanical lift tilted and Resident #1 fell out and hit her head. She stated that LPN #1 and CNA #4 were also in the room watching her lift Resident #1. CNA #2 confirmed that there was no staff holding on to Resident #1 while she was lifting Resident #1 from the bed to the wheelchair. CNA #2 stated that Resident #1 fell out of the lift and hit her head and she began to bleed. She stated that LPN #1 told CNA #2 to continue to lower Resident #1 to the floor so they could assess her and treat her bleeding head. LPN #1 assessed Resident #1 while she was on the floor and then all four (4) of the staff (CNA #2, CNA #3, CNA #4 and LPN #1) assisted to transfer Resident #1 from the floor back into the bed, where LPN #1 re-assessed Resident #1 while she was in the bed. Resident #1 was transported to the hospital with a head injury on 10/01/24 at approximately 9:00 A.M. On 10/22/24 at 1:30 PM, during an interview with CNA #3 revealed that she was not in the room with CNA #2 when she used the mechanical lift to transfer Resident #1. CNA #3 stated that she was with another resident assisting with her breakfast when (CNA #2) came and got her to help with Resident #1. CNA #2 stated that upon entering Resident #1's room there were no other staff present and Resident #1 was on the floor bleeding from the forehead. CNA #3 stated that	M 640		

MSDH - Health Facilities Licensure and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 40CH	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 10/22/2024
NAME OF PROVIDER OR SUPPLIER TREND HEALTH & REHAB OF CARTHAGE LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 1101 EAST FRANKLIN STREET CARTHAGE, MS 39051		
(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) COMPLETE DATE
M 640	Continued From page 26 CNA #2 had used the mechanical lift alone without a second staff and Resident #1 had fallen and received a head injury. They called LPN #1 and CNA #4 came along with LPN #1 to help get Resident #1 up off of the floor and back into the bed. The four (4) staff together assisted Resident #1 back to her bed where LPN #1 assessed the resident. CNA #3 confirmed that she had provided a hand written statement to the facility Director of Nursing (DON) confirming that she was not in the room when Resident #1 fell from the lift. CNA #3 reviewed her hand written statement with the State Agency (SA) and confirmed that was her statement that was given to the DON. CNA #3 stated that she had in past times assisted with the transfer of Resident #1 with a mechanical lift and there had never been any issues with Resident #1 resisting care or moving about while in the sling of the mechanical lift. CNA #3 verbalized that Resident #1 was a large lady and that she required at least two (2) persons to assist with her care and to steady the mechanical lift. CNA #3 stated that Resident #1 never moved and was unable to move or wiggle. CNA #3 again confirmed that she was not in the room when CNA #2 was utilizing the lift and that she had told the DON that in her statement. On 10/22/24 at 2:25 PM, an interview with the Assistant Director of Nursing (ADON) and the Administrator (ADM) confirmed that the two (2) person assist method required that two (2) staff would both assist with the operation of the lift and with the proper attachment of the sling. Both the ADON and the ADM confirmed that they were not aware that CNA #2 had transferred Resident #1 with the lift by herself. Both the ADON and the ADM expressed that they were under the impression that the DON had thoroughly investigated the incident and had determined that	M 640		

MSDH - Health Facilities Licensure and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 40CH	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 10/22/2024
NAME OF PROVIDER OR SUPPLIER TREND HEALTH & REHAB OF CARTHAGE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 1101 EAST FRANKLIN STREET CARTHAGE, MS 39051		
(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) COMPLETE DATE
M 640	Continued From page 27 there was three (3) staff assisting CNA #2 with the mechanical lift. "Not until today were we made aware that the incident happened another way," stated the ADM. The ADM stated that on 10/02/24 Resident #1 was sent from the local ER for a hip fracture and had never returned to the facility and had been discharged from the facility. The ADM stated that she would talk to the DON when she returned to the facility from medical leave. The record review of the investigation completed by the facility's DON was not consistent with the hand written statements of the CNAs nor the LPN's hand written statement. The DON did not investigate the incident in accordance with the facility's policies and procedures for the operation and use of mechanical lifts and for Abuse and Neglect. On 10/25/24, after the SA had exited the survey, the facility's ADON notified via email and confirmed that they had re-interviewed and the CNAs and LPN involved with the incident of Resident #1's fall from the mechanical lift and that CNA #2, CNA #4 and LPN #1 confessed that they had not been truthful and had lied on their original statements that they gave to the DON on 10/1/24-10/3/24. CNA #2 confessed that she used the mechanical lift alone and improperly and that the other CNAs were not in the room when the fall of Resident #1 occurred. LPN #1 and CNA #4 both gave new statements that they were not present in the room with CNA #2 when Resident #1 fell and received serious injury and that they had falsified their statements and had not been truthful during the investigation. Record review of the hand written statement that was provided to the DON on 10/03/24 by CNA #3 revealed, "On October 1, 2024 I was walking to feed a resident, as I was alerted to come in	M 640			

MSDH - Health Facilities Licensure and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 40CH	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 10/22/2024
NAME OF PROVIDER OR SUPPLIER TREND HEALTH & REHAB OF CARTHAGE LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 1101 EAST FRANKLIN STREET CARTHAGE, MS 39051		
(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) COMPLETE DATE
M 640	Continued From page 28 (Resident #1's) room. Once I walked into the room she was already laying on the floor. The nurse examined her. Then me, nurse, and another aide proceeded to help get her up off the floor and put back into the bed." The hand written statement was signed by CNA #3 and dated 10/3/2024. Record review of the hand written statement that was provided to the DON on 10/1/24 and signed by (CNA #4) revealed, "As me, (CNA #3), and (LPN#1) was walking in the room she began to lifted (Resident #1) as she was lifting she slipped out the sling hit her head on the wheel of the wheel chair..." Record review of the hand written statement that was provided to the DON on 10/3/24 by CNA #2 revealed, "I (CNA #2) gave (Resident #1) a bedbath for shower Day; got her fully dressed to get up. I made sure she was pulled up in bed before stepping out. Went to shower room and grab the total lift and brought into room, had her chair by bed being prepared to get her up. I went to door to ask someone to spot me with lift So (LPN #1) (the nurse) and two CNA came behind her as I was proceeding to transfer her to put in chair. The total lift tilted over and (Resident #1) fell and Hit her head on the edge of her chair leg." The hand written statement was signed by CNA #2 and dated 10/3/24. Record review of the undated hand written statement provided to the DON by LPN #1 stated, "I was asked to step in the room to assist with a total transfer, along with 2 other staff. Once I stepped into the room. Staff began to lift her off the bed. Once lifted she steered the lift to get her over the wheelchair. As she began to steer the lift, resident slipped out of sling hitting her head	M 640		

MSDH - Health Facilities Licensure and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 40CH	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 10/22/2024
NAME OF PROVIDER OR SUPPLIER TREND HEALTH & REHAB OF CARTHAGE LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 1101 EAST FRANKLIN STREET CARTHAGE, MS 39051		
(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) COMPLETE DATE
M 640	Continued From page 29 on the front of wheelchair." Record review of "After Visit Summary, dated 10/01/24, from the hospital stated, "Tylenol only for pain. Monitor wound for any development of infection. Return for vomiting, weakness, lethargy." "Reason for visit: Fall." Record review of Hospital ER report dated 10/02/24 and titled, "CT Abdomen Pelvis with contrast," revealed "Reason for visit n/v (nausea and vomiting)" "Results: Acute appearing right femoral intertrochanteric fracture." Record review of the Section C of the Minimum Data Set (MDS) dated 09/12/2024 for Resident #1 revealed she was severely cognitively impaired. The record review of the Admission Record of Resident #1 revealed that she was admitted to the facility on 11/22/2022 with diagnosis of Cerebral Infarction Due to Embolism of left middle cerebral artery; among many other diagnoses.	M 640		