

MSDH - Health Facilities Licensure and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09FD	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 04/02/2025
NAME OF PROVIDER OR SUPPLIER TREND HEALTH AND REHAB OF HOUSTON		STREET ADDRESS, CITY, STATE, ZIP CODE 1000 EAST MADISON STREET HOUSTON, MS 38851		
(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 an annual recertification survey and a complaint investigation (CI) MS #28305 at the facility from 3/30/25 through 4/2/25. During the survey, the SA determined the facility was not in compliance with the Minimum Standards for Institutions for the Aged or Infirm, state licensure requirements and deficiencies were cited at M 500, M 610, M 780 and M 1570. The SA determined the facility was not in compliance with CI MS #28305 regarding residents rights and cited M 500 was also cited for this complaint in addition to the annual survey. The facility had a census of 45 at the time of the survey and held a license for 60 beds.	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;	M 500		5/15/25

Mississippi State Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

04/21/25

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M 500	Continued From page 1 3. is assured of adequate and appropriate 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,	M 500		

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M 500	Continued From page 2 free from restraint, interference, coercion, 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		

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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:	M 500		

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M 500	Continued From page 4 Level II Based on resident and staff interviews, record review and facility policy review, the facility failed: 1) to honor a resident's bedtime choice (Resident #24) and; 2) to deliver resident mail on Saturdays (Resident's #4, #20, #22, #35 and #38) for six (6) of 31 sampled residents. Findings Include: Self-determination: Record review of the facility policy "Resident Rights" revealed "...3. Our facility will make every effort to assist each resident in exercising his/her rights to ensure that the resident is always treated with respect, kindness, and dignity..." An interview on 3/31/25 at 1:00PM with the Administrator (ADM) revealed that on 03/16/25, Registered Nurse (RN) #1 called her and reported that Certified Nursing Assistant (CNA) #1 made Resident #24 go to bed when she didn't want to. The ADM stated that RN #1 reported to her that CNA #1 took Resident #24 to her room from the dining room after the supper meal around 6:00 PM, put Resident #24's gown on and made her go to bed. She also revealed that Resident #24 kept telling her (CNA #1) that she didn't want to go to bed. The ADM reported that Resident #24's roommate, Resident #22 witnessed it, walked up to the nursing desk and reported to RN #1 that CNA #1 told Resident #24 that she was going to bed because she (CNA #1) had things to do. The ADM admitted that it was the residents' right to choose to get up and to go to bed when they wanted to, and Resident #24's choice to stay up longer should have been honored that evening.	M 500	m 500 " Resident #24 is going to bed or staying up as she desires. On 3-16-25 the RN Supervisor went to Resident # 24s room and explained to the resident her right to not go to bed until she was ready. The RN Supervisor asked the resident if she would like to get back up and that she would assist her in getting back up and the resident declined. On 04-01-25 the Business Office Manager (BOM) checked the Business Office to ensure that any mail that had been delivered to the facility had also been delivered to the residents. On 04-02-25 the BOM met with Residents #4, # 45, #22, #35 and #38 and informed them that they do not currently have any mail to be delivered. On 04-02-25 the Administrator notified the United States Postal Service of the requirement to have mail delivered to the facility on Saturdays. " Residents that require assistance with transfers and residents who receive mail are at risk for the deficient practice. " The Administrator and the Director of Nursing in-serviced the staff on Resident Rights and Abuse/Neglect on 03-17-25. The Administrator addressed the Resident Council on 04-04-25, regarding Resident Rights and Abuse/Neglect. On 04-04-25 the Administrator in-serviced the weekend nursing supervisor of mail being delivered by the postal service on Saturdays and the responsibility of the weekend supervisor to take the mail to the residents room when it arrives from the mail carrier. " The Administrator will make rounds and speak with two residents weekly x 4 weeks that require assistance with transfers and that receive mail to ensure	

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M 500	Continued From page 5 An interview with Resident #22 on 03/31/25 at 1:40 PM confirmed that she was Resident#24's roommate and a couple of weeks ago, she saw a CNA make Resident #24 go to bed one night after supper. She revealed that she didn't know who the CNA was, but she hadn't been back since that night, and she was glad. Resident #22 revealed that she was in her bed watching television with her privacy curtain pulled about halfway to where she could see what was going on. She confirmed that she heard the CNA say to Resident #24, "You're going to bed because I have work to do." She revealed that she heard Resident #24 tell the CNA several times that she was not ready to go to bed. Resident #22 revealed that she got up from her bed and went to the nursing desk and reported to a nurse what happened. An interview on 03/31/25 at 2:35 PM with RN #1 confirmed that around 5:45 PM on 3/16/25 Resident #22 came to the nurse's desk and reported that CNA #1 was mistreating Resident #24 by making her go to bed when she didn't want to. RN #1 revealed that Resident #22 told her that Resident #24 told CNA #1 that she was not ready to go to bed and the CNA told her she was going to bed anyway because she had too much to do. RN #1 revealed that she went to Resident #24's room to check on her and found her sitting on the side of the bed with her gown on. RN #1 revealed that Resident #24 told her that she wanted to stay up longer and visit with friends in the dining room and wasn't ready to go to bed but that CNA #1 made her go to bed. RN #1 revealed that she made sure Resident #24 was safe, offered to put her clothes back on and help her get back up but at that time, she refused. RN #1 revealed that Resident #24 told her that she was sitting in the dining room at a table with	M 500	that their rights are being met beginning 04-16-25. The Administrator will meet with residents at Resident Council for three months beginning on 04-16-25 about Residents Rights and if they are being honored. The BOM will check mail on Monday's beginning 04-21-25 for four weeks to ensure that the mail is not left from the weekend. The Administrator will meet with the weekend charge nurse weekly beginning on 04-16-25 to ensure that residents that receive mail on Saturday's is being delivered to the residents upon arrive from the mail carrier. The Administrator will bring audits to the monthly Quality Assurance (QA) meeting for three months for recommendations or changes needed to ensure consistent substantial compliance beginning 05-14-25." " " "	

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M 500	Continued From page 6 other residents and CNA #1 came and pushed her in her wheelchair back to her room and put her to bed, even though she told her she was not ready. RN #1 confirmed that Resident #24's choice to go to bed later that evening should have been honored and this was not okay. An interview on 04/01/25 at 10:20 AM with Resident #24 confirmed that a couple weeks ago, there was an aid who made her go to bed early against her wishes. She revealed that she thought it was around 6:00 PM and she was sitting in her wheelchair at a table in the dining room visiting with friends when the aid came and pushed her back to her room. Resident #24 revealed that she told the aid that she was not ready to go to bed, but the aide told her she was going anyway because she had a lot of work to do. Resident #24 revealed that this was her home, and she wanted to be good to the staff here and she wanted them to be good to her. Resident #24 revealed that it was important to her to make her own decisions about when to go to bed and she wanted to be respected. Resident #24 revealed that the aide did not hurt her, just made her go to bed. She revealed that sometimes she wanted to go to bed early but that was her choice. She revealed that if the aide wasn't going to do right, she didn't need to work there. Resident #24 revealed that she did not know who the aide was and that she hadn't been back to work since that happened. Record review of Resident #24's "Admission Record" revealed the facility admitted the resident on 09/02/22 with medical diagnoses that included Parkinson's Disease and Depression . Record review of Resident #24's Minimum Data Set (MDS) with an (Assessment Reference Date)	M 500		

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M 500	Continued From page 7 (ARD) of 01/13/25 under Section C revealed a Brief Interview for Mental Status (BIMS) Score of 8 which indicated that she had moderate cognitive deficits. The review of Section F-Preferences revealed that it was very important to her to choose her own bedtime. Right to forms of communication: Record review of the facility policy "Mail Delivery Policy" dated 2/2009 revealed, "The mail will be delivered to the resident Monday thru Friday by the Activity Director. If the resident receives mail on Saturday, it will be delivered to the resident by the week-end RN (Registered Nurse) Unit Manager." During a Resident Council Meeting on 03/31/25 at 2:00 PM five of the thirteen residents in attendance revealed that they did not have mail delivered on Saturdays. Resident #38, Resident Council President, revealed that there was no one in the front office on the weekend to pass the mail out to them. Resident #4, Resident #20, Resident #22, and Resident #35 confirmed that the staff handed their mail out during the week and that they did not get mail on Saturdays. An interview on 03/31/25 at 3:40 PM with Registered Nurse (RN) #1, revealed that she worked on the weekends and that she hadn't ever accepted mail on Saturdays. She revealed that the front office was closed on the weekends. RN #1 revealed that if mail was delivered to the facility on Saturdays, she could pass it out to the residents. An interview on 04/01/25 at 9:10 AM with the Director of Nursing (DON), revealed that the mail carrier did not deliver mail to the facility on	M 500		

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M 500	Continued From page 8 Saturdays because there was no one in the front office to give it to. She revealed that if the facility had any mail on Saturdays, the mail carrier delivered it the following Monday when they had someone to distribute it to. DON agreed that residents should receive their mail on Saturdays if they had any, and they should not have to wait until the following Monday to get it. On 04/01/25 at 10:00 AM, an interview with the Administrator (ADM) revealed that there had been some inconsistencies with the mail but she was not aware that mail was not delivered on Saturdays. ADM confirmed that it was important for the residents to receive their mail and that it should be passed out on the days the mail ran. Record review of Resident #4's "Admission Record" revealed an admission date of 04/17/08. Record review of Resident #4's Quarterly Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 01/27/25 under Section C revealed a Brief Interview for Mental Status (BIMS) score of 15 which indicated that she had no cognitive deficits. Record review of Resident #20's "Admission Record" revealed an initial admission date of 12/13/18. Record review of Resident #20's Quarterly MDS with ARD 12/4/24 under Section C revealed a BIMS Score of 15 which indicated that she had no cognitive deficits. Record review of Resident #22's "Admission Record" revealed an admission date of 11/04/24. Record review of Resident #22's Quarterly MDS	M 500		

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M 500	Continued From page 9 with ARD of 02/06/25 under Section C revealed a BIMS Score of 15 which indicated that she had no cognitive deficits. Record review of Resident #35's "Admission Record" revealed an admission date of 03/25/22. Record review of Resident #35's Quarterly MDS with ARD of 11/19/25 under Section C revealed a BIMS Score of 15 which indicated that she had no cognitive deficits. Record review of Resident #38's "Admission Record" revealed an initial admission date of 07/22/22. Record review of Resident #38's Quarterly MDS with ARD of 12/09/24 under Section C revealed a BIMS Score of 15 which indicated that she had no cognitive deficits.	M 500			