STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255306	A. BUILDING _____ B. WING _____	C 04/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TREND HEALTH AND REHAB OF HOUSTON	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) COMPLETION DATE
F 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 requirements of participation in Medicare and Medicaid and cited regulatory deficiencies at F576, F640, F641, F656, F677, F679, and F880. The SA found the facility not to be in compliance with CI MS #28305 regarding residents' choices and cited F561. The facility had a census of 45 at the time of survey and was licensed for 60 beds.	F 000		
F 561 SS=D	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in	F 561		5/15/25

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

Electronically Signed | 04/21/2025

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 561	Continued From page 1 community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on resident and staff interviews, record review and facility policy review, the facility failed to honor a resident bedtime choice for one (1) of 31 sampled residents. Resident #24. Findings Include: 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)	F 561	F 561 • Resident #24 is going to bed or staying up as she desires. On 3-16-25 the RN Supervisor went to Resident # 24's 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. • Residents that require assistance with transfers 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. • The Administrator will make rounds and speak with two residents weekly x 4 weeks that require assistance with transfers to ensure that their rights are being met beginning 04-16-25. The Administrator will ask residents at Resident Council Meetings about Residents' Rights and if they are being honored monthly for three months. The Administrator will bring audits to the	

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F 561	Continued From page 2	F 561		

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.

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

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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F 561	Continued From page 3	F 561		

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 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.

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F 561	Continued From page 4 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) (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.	F 561		