

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255108		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 09/24/2025	
NAME OF PROVIDER OR SUPPLIER TREND HEALTH & REHAB OF CARTHAGE LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 1101 EAST FRANKLIN STREET , CARTHAGE, Mississippi, 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) COMPLETION DATE	
F0000	INITIAL COMMENTS The State Agency (SA) conducted an onsite complaint investigation (CI) MS # 500578 at the facility on 9/24/25. During the survey, SA determined that the facility was not compliance with the requirements of participation in Medicare and Medicaid Services and cited F684 related to quality of care. The SA investigated quality of care, accidents and hazards, and activities of daily living. The census at the time of the survey was 74 with a bed capacity of 83 beds.		F0000				
F0684 SS = D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is NOT MET as evidenced by: Based on interviews and record review, the facility failed to ensure Resident #1 received necessary care and services in accordance with physician orders when staff did not obtain and implement a nephrologist's order to increase Lasix. This was identified for one (1) of three (3) residents reviewed for quality of care (Resident #1). Findings include: A phone interview with the complainant on 9/23/25 at 4:00 PM revealed Resident #1 attended a nephrology appointment in April 2025, where the nephrologist ordered Lasix to be increased to 40 milligrams (mg) twice daily. The complainant stated she returned the consultation paperwork to the facility nurse after the		F0684				

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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F0684 SS = D	Continued from page 1 appointment. She reported that in May the resident began experiencing worsening leg swelling and weakness, and therapy was discontinued. She later learned the increased Lasix order had not been implemented. The complainant stated she believed the resident's hospitalization was a direct result of the missed medication orders. Record review of the April 2025 appointment calendar revealed Resident #1 had a nephrology appointment on 4/21/25. Record review of the nephrology consultation report dated 4/21/25 revealed: "Plan: Increase Lasix to 40 mg in the morning and 40 mg at noon." Record review of the Order Summary Report revealed Lasix was not increased to 40 mg twice daily until 5/8/25, seventeen days after the consultation. During an interview with the Director of Nursing (DON) on 9/24/25 at 9:00 AM, she confirmed the consultation paperwork was not in the record and the Lasix order was not implemented on 4/21/25. She acknowledged the family had discussed the medication changes with the previous DON, but orders were not entered until 5/8/25. She confirmed failure to obtain the consultation form and follow-through with medication changes could result in resident decline. During an interview with the Medical Records staff on 9/24/25 at 10:30 AM, she stated consultation forms are given to the unit managers, who are responsible for ensuring orders are transcribed. She confirmed that if forms are missing, staff should follow up with the provider, but no follow-up occurred in this case. During an interview with the Unit Manager on 9/24/25 at 10:35 AM, she acknowledged the form may have been misplaced but confirmed staff should have followed up with the DON or Assistant Director of Nursing (ADON) to obtain the orders. During a continued interview with the DON on 9/24/25 at 10:40 AM, she confirmed that Resident #1 experienced worsening edema requiring hospital transfer on 5/12/25. An interview with the Administrator on 9/24/25 at 11:04 AM confirmed he was not aware that Resident #1's Lasix had not been increased as ordered or that the consultation sheet was missing from the record. He stated it was his expectation that if staff did not receive the forms, they should have followed up to obtain the information.			F0684			

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F0684 SS = D	Continued from page 2 An interview with the ADON on 9/24/25 at 11:10 AM revealed she obtained orders to transfer Resident #1 to the hospital on 5/12/25 due to increased edema and fever. Record review of the Emergency Department notes dated 5/12/25 revealed Resident #1 was admitted with edema and urinary tract infection. Review of the "Admission Record" revealed Resident #1 was admitted to the facility on 3/27/25 with diagnoses including chronic obstructive pulmonary disease, pulmonary hypertension, diastolic heart failure, and chronic kidney disease. Record review of the Minimum Data Set with an Assessment Reference Date (ARD) of 4/3/25 revealed in Section C a Brief Interview for Mental Status (BIMS) score of 04, which indicated Resident #1 is severely cognitively impaired.		F0684				