STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **09/24/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TREND HEALTH & REHAB OF CARTHAGE LLC	**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
M0000	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 Mississippi Regulations for Minimum Standards for Institutions for the Aged or Infirm and cited M500. 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.	M0000		
M0500	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 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	M0500		

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

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M0500	Continued from page 1 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, 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	M0500		

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M0500	Continued from page 2 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; 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	M0500		

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M0500	Continued from page 3 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 LICENSURE REQUIREMENT is NOT MET as evidenced by: Level II 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 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	M0500		

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M0500	Continued from page 4 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. 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.	M0500		