STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255169	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 10/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TREND HEALTH AND REHAB OF NATCHEZ, LLC	**587 JOHN R JUNKIN DRIVE , NATCHEZ, Mississippi, 39120**

(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 a Complaint Investigation (CI), MS #2620782, at the facility from 10/29/25 through 10/30/25. MS #2620782 was investigated related to resident rights and quality of care. During the survey, the SA determined the facility was not in compliance with the requirements for participation in Medicare and Medicaid and cited F-550. The facility held a license for 100 beds, with a census of 67.	F0000		
F0550 SS = D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States.	F0550		

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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F0550 SS = D	Continued from page 1 §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is NOT MET as evidenced by: Based on interview, record review, and facility policy review, the facility failed to ensure that 1 (one) of three (3) residents reviewed for dignity and respect was treated in a manner that maintained and upheld her personal dignity. This failure resulted in the resident feeling embarrassed and uncomfortable when two Certified Nurse Assistants (CNAs) made an inappropriate comment during personal care. Resident #1. Findings include: A record review of the facility policy “Resident Rights” updated 4/4/25 revealed, “Employees shall treat all residents with kindness, respect, and dignity. Resident #1: Record review of the “Admission Record” revealed the facility admitted Resident #1 on 5/20/25 with diagnoses including cerebral infarction. Record review of the Quarterly “Minimum Data Set (MDS)” with an Assessment Reference Date (ARD) of 8/21/25 revealed a Brief Interview for Mental Status (BIMS) summary score is 13, indicating Resident #1 is cognitively intact. A review of the facility’s investigation revealed that on 9/17/25 at approximately 12:17 PM, Resident #1 reported to Social Services that two (2) staff members had made remarks that hurt her feelings and caused her to feel bad about herself. The Director of Nursing (DON) immediately informed the Administrator-in-Training (A-IT). Resident #1 reported that as she was leaving her room and heading toward the shower room, her gown was hanging off her shoulder, exposing part of her chest. Certified Nurse Assistant (CNA) #2 commented, “Just leave her alone, she just	F0550		

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F0550 SS = D	Continued from page 2 wants the old men to look at her." Following her shower, CNA #1 assisted the resident with dressing and remarked that the resident was gaining weight and thought her brother was going to bring her some clothes that fit. Both comments made the resident feel embarrassed and bad about herself. The facility immediately initiated an investigation and reported the incident to the State Agency (SA) through the abuse hotline and to the Attorney General's Office (AGO). Both staff members were placed on administrative leave pending the investigation and were subsequently terminated for improper conduct. On 10/29/25 at 1:30 PM, during an interview with Resident #1, she confirmed that several weeks earlier, two (2) Certified Nurse Assistants (CNAs) spoke to her in a rude and disrespectful manner. While preparing for her shower, her gown did not fully cover her, and one of the CNAs commented, "You just want the men to look at you." Resident #1 explained, "That hurt my feelings because I don't want any men to look at me in that way. I'm a young woman and a nurse who had a stroke." She reported the comment made her feel embarrassed and uncomfortable. Resident #1 informed facility staff of the incident and requested that the two CNAs no longer assist with her care. On 10/30/25 at 3:00 PM, during an interview with the Administrator, she confirmed that on 9/17/25, the facility was notified of an incident involving Resident #1 and two Certified Nurse Assistants (CNAs) who made an inappropriate comment to the resident during care. The Administrator stated the comment was unprofessional and did not reflect the facility's expectations for maintaining resident dignity and respect. She confirmed that both CNAs were immediately removed from resident care pending investigation. The Administrator revealed Resident Rights Policy requires all staff to treat residents with respect at all times and prohibits language or behavior that could be perceived as demeaning. She confirmed both CNAs were interviewed and admitted that a comment was made "as a joke." The Administrator stated the facility determined the behavior violated policy and both CNAs were terminated. She verified that on 9/17/25, all nursing staff received re-education on professional communication, resident dignity, and maintaining respectful interactions. On 10/30/25 at 3:15 PM, during an interview with the Director of Nursing (DON), she explained that on 9/17/25 she was notified by Social Services that Resident #1 had reported an inappropriate comment made by two Certified Nurse Assistants (CNAs) during care.	F0550		

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F0550 SS = D	Continued from page 3 The DON reported that the comment was unprofessional and inconsistent with the facility's expectations for treating residents with dignity and respect. She immediately ensured the resident was safe and that both CNAs were removed from resident care while the matter was reviewed. The DON confirmed she interviewed the CNAs involved, the resident, and relevant staff. Both CNAs admitted a comment was made "as a joke." The DON indicated she counseled the resident, who expressed embarrassment and discomfort, and provided reassurance that her concerns were taken seriously. Following the investigation, both CNAs were terminated for unprofessional conduct that failed to uphold resident dignity. The DON verified that on 9/17/25, following the incident, all nursing staff received re-education on professional communication, sensitivity, and maintaining resident dignity at all times. On 10/30/25 at 3:30 PM, during an interview with the Social Services Director, she confirmed that on 9/17/25 Resident #1 reported two Certified Nurse Assistants (CNAs) had spoken to her in a rude and inappropriate manner during shower preparation, making a comment that left her feeling embarrassed and hurt. The Social Services Director explained she immediately notified the Director of Nursing (DON), documented the concern, and provided emotional support to the resident. She verified that the facility initiated a review the same day in accordance with the Resident Rights and Dignity Policy, which requires all staff to communicate respectfully and maintain each resident's dignity at all times. On 10/29/25 at 3:40 PM, during a phone interview with CNA #1, she explained that while assisting Resident #1 to get dressed following her shower, the resident mentioned her brother was supposed to bring her larger clothes because she had been gaining weight. CNA #1 agreed with the resident that her clothing appeared to be getting tighter. She denied making any comments intended to be rude or disrespectful and reported she was only agreeing with what the resident had said. CNA #1 added that after assisting the resident, the resident did not appear upset or indicate that her feelings had been hurt. She commented, "I would never say anything to hurt a resident's feelings." On 10/29/25 at 3:45 PM, during a phone interview with CNA #2, she explained that on 9/17/25 she observed Resident #1 rolling down the hallway with her gown exposing her shoulder area. Another CNA asked her to assist the resident and help cover her up. CNA #2 recalled telling the other CNA that if the resident chose to move about the facility with her shoulder	F0550		

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F0550 SS = D	Continued from page 4 exposed, “that’s her business—this is her home.” CNA #2 denied making any direct comments to the resident and reported she did not say anything out loud that the resident could have overheard or perceived as disrespectful. She emphasized that she always tries to respect residents’ privacy and dignity.	F0550		