Mississippi State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(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
M0000	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 Minimum Standards for Institutions for the Aged or Infirm, state licensure requirement. The facility was cited M-500.	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 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	M0500		

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

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M0500	Continued from page 1 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 and monitoring of restraint. A physician order for restraint must be countersigned within 24 hours of the emergency application of the restraint;	M0500		

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M0500	Continued from page 2 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 the medical record); and 16. is assured of exercising his civil and religious	M0500		

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M0500	Continued from page 3 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 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 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	M0500		

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M0500	Continued from page 4 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. 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	M0500		

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M0500	Continued from page 5 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 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.	M0500		