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 03/23/2026

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
F0000	INITIAL COMMENTS The State Agency (SA) conducted a Complaint Investigation (CI MS# 2684559) at the facility on 3/23/26. During the survey, the SA determined that the facility was not in compliance with the requirements of participation in Medicare and Medicaid Services. The SA identified non-compliance and cited F585 for CI MS# 2684559 related to unresolved grievances. The census at the time of the survey was 78 with a bed capacity of 82 beds.	F0000		
F0585 SS = E	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include:	F0585		

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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F0585 SS = E	Continued from page 1 (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system; (ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations; (iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated; (iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the	F0585		

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F0585 SS = E	Continued from page 2 residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is NOT MET as evidenced by: Based on record review, interview, and facility policy review, the facility failed to ensure that resident grievances voiced through the Resident Council were thoroughly investigated, addressed, and resolved for three (3) of three (3) residents reviewed for grievances (Residents #1, #2, and #3). Findings Included: Record review of the facility policy “Resident and Family Grievances/Complaints” revealed “Policy: It is the policy of this facility to support each resident’s and family member’s right to voice grievances without discrimination, reprisal or fear of discrimination or reprisal…12. The facility will make prompt efforts to resolved grievances...” A record review of “Resident Council Minutes”, dated 11/20/25, revealed that residents complained that “food on the weekend has gotten bad.” There was no documentation that the complaint had been addressed by the facility. A record review of “Resident Council Minutes”, dated 12/22/25, revealed that residents complained that “food is cold once it comes down the hallway.” A record review of the “Resident Council Department Response Form”, dated 12/22/25, revealed that the Dietary Manager reported that food was placed in containers to hold temperature until it reached the residents and that an in-service was conducted for dietary staff on 1/9/26 to improve food service. There was no further documentation to indicate that follow-up or monitoring was conducted to ensure the concern was resolved. A record review of “Resident Council Minutes”, dated 1/15/26, revealed that residents continued to complain that the “food on the weekend was not good and tasted	F0585		

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F0585 SS = E	Continued from page 3 sweet, the water and tea do not have enough ice, breakfast biscuits and toast are hard and the grits are cold." A record review of the "Resident Council Department Response Form", dated 1/15/26, revealed that the Dietary Manager (DM) indicated a meeting would be held with weekend staff to address the issue. There was no further documentation to indicate that the concern was investigated or resolved. A record review of "Resident Council Minutes", dated 2/19/26, revealed that residents continued to complain that the food was cold. A record review of the "Resident Council Department Response Form", dated 2/19/26, revealed that the Dietary Manager reported that food was being sent out faster and that staff were instructed to pass trays promptly. There was no further documentation to indicate that monitoring, follow-up, or evaluation of effectiveness was completed. An interview with Resident #1 on 3/23/26 at 2:00 PM, revealed that the food was still not good and was always cold. She stated that it was not about seasoning, but that the food overall did not taste good. An interview with Resident #2 on 3/23/26 at 2:15 PM, revealed that the food was still cold when served and did not taste good, although alternate meals were available. An interview with Resident #3 on 3/23/26 at 2:20 PM, revealed that the food tasted bad and was always cold. He stated that staff would heat the food if requested; however, the food was consistently served cold. An interview with the Dietary Manager on 3/23/26 at 3:00 PM, revealed that he was aware of the residents' complaints regarding food from Resident Council meetings. He stated that he had spoken with weekend staff and made changes such as replacing tray carts and providing guidance on food preparation; however, he acknowledged that there was no documentation of ongoing monitoring, follow-up, or additional interventions to ensure that the concerns were resolved. An interview with Social Services on 3/23/26 at 3:16 PM, she verified that she was aware of the Resident Council complaints about the food but had not followed up to determine what was done or if the issue was resolved.	F0585		

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F0585 SS = E	Continued from page 4 An interview with the Administrator on 3/23/26 at 3:30 PM, revealed that he was aware of the residents' complaints regarding food and acknowledged that additional follow-up and resolution efforts should have occurred to ensure that the grievances were resolved. Record review of the "Admission Record" revealed that the facility admitted Resident #1 to the facility on 7/7/24 with a diagnosis of Type 2 Diabetes Mellitus. Record review of Section C of the "Minimum Data Set Assessment" (MDS) with an Assessment Reference Date (ARD) of 3/5/26 revealed Resident #1 has a Brief Interview for Mental Status (BIMS) score of 15, indicating that she is cognitively intact. Record review of the "Admission Record" revealed that the facility admitted Resident #2 to the facility on 10/16/24 with a diagnosis of Polyneuropathy. Record review of Section C of the MDS with an ARD of 2/14/26 revealed Resident #2 has a BIMS score of 13, indicating that she is cognitively intact. Record review of the "Admission Record" revealed that the facility admitted Resident #3 to the facility on 11/16/21 with a diagnosis of Quadriplegia. Record review of Section C of the MDS with an ARD of 2/14/26 revealed Resident #3 has a BIMS score of 15, indicating that he is cognitively intact.	F0585		