STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255306	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 05/28/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TREND HEALTH AND REHAB OF HOUSTON	**1000 EAST MADISON STREET , HOUSTON, Mississippi, 38851**

(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 Annual Recertification survey at the facility on 5/26/26 through 5/28/26. During the survey, the SA determined that the facility was not in compliance with the requirements of participation in Medicare and Medicaid Services and cited F637, F641, F692, F695, and F880. The census at the time of the survey was 53 with a license for 60 beds.	F0000		
F0637 SS = D	Comprehensive Assessment After Signifcant Chg CFR(s): 483.20(b)(2)(ii) §483.20(b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is NOT MET as evidenced by: Based on record review, staff interview, and facility policy review, the facility failed to complete a Significant Change in Status Minimum Data Set (MDS) assessment for one (1) of seven (7) residents reviewed for hospice services. Resident #36 Findings include: Review of the facility policy titled “MDS Assessment”, with a revision date of 5/2006, revealed “Policy It is the policy of this facility to follow the RAI (Resident Assessment Instrument) process as set forth by CMS (Centers for Medicare and Medicaid) protocol.” Record review revealed Resident #36 was admitted to hospice services on 3/11/25. Review of the resident's MDS assessment record revealed no Significant Change in Status Assessment was completed following hospice	F0637		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255306	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 05/28/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TREND HEALTH AND REHAB OF HOUSTON	**1000 EAST MADISON STREET , HOUSTON, Mississippi, 38851**

(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
F0637 SS = D	Continued from page 1 admission. During an interview on 5/27/2026 at 3:27 PM, the MDS nurse confirmed a Significant Change in Status Assessment should have been completed when Resident #36 admitted to hospice services and it was not completed.Record review of the “Admission Record” revealed the facility admitted Resident #36 on 12/01/22 with medical diagnoses including Alzheimer's Disease. Record review of the MDS with an Assessment Reference Date (ARD) of 4/16/26 revealed, under Section C, a Brief Interview for Mental Status (BIMS) summary score of 3, indicating Resident #36 was severely cognitively impaired.	F0637		
F0641 SS = D	Accuracy of Assessments CFR(s): 483.20(g)(h)(i)(j) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. §483.20(h) Coordination. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. §483.20(i) Certification. §483.20(i)(1) A registered nurse must sign and certify that the assessment is completed. §483.20(i)(2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. §483.20(j) Penalty for Falsification. §483.20(j)(1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. §483.20(j)(2) Clinical disagreement does not	F0641		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255306	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 05/28/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TREND HEALTH AND REHAB OF HOUSTON	**1000 EAST MADISON STREET , HOUSTON, Mississippi, 38851**

(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
F0641 SS = D	Continued from page 2 constitute a material and false statement. This REQUIREMENT is NOT MET as evidenced by: Based on record review, staff interview, and facility policy review, the facility failed to accurately complete Section N Medications section of the Minimum Data Set (MDS) assessment for one (1) of 17 residents reviewed for MDS accuracy. Resident #4. Findings Include: Review of the facility policy titled “MDS (Minimum Data Set) Assessment” dated 5/2006 revealed, “Policy It is the policy of this facility to follow the RAI (Resident Assessment Instrument) process as set forth by CMS (Centers for Medicare and Medicaid) protocol...” Record review of Resident #4’s MDS with an Assessment Reference Date (ARD) of 3/31/26 revealed, under Section N, that during the 7-day look-back period the resident was coded as receiving an antianxiety, antidepressant, hypnotic, and anticoagulant medication. Record review of Resident #4’s March 2026 “Medication Administration Record” revealed the resident did not receive an antianxiety, antidepressant, hypnotic, or anticoagulant medication during the assessment period, confirming the MDS was not accurately completed. An interview with the MDS Nurse on 5/27/26 at 1:45 PM confirmed Resident #4’s MDS was incorrect and had been coded in error. She revealed the purpose of an accurate assessment was to ensure the resident’s plan of care was developed appropriately so staff could provide the necessary care. Record review of the “Admission Record” revealed the facility admitted Resident #4 on 3/25/26 with medical diagnoses including Metabolic Encephalopathy. Record review of the MDS with an ARD of 3/31/26 revealed, under Section C, a Brief Interview for Mental Status (BIMS) summary score of 11, indicating Resident #4 was moderately cognitively impaired.	F0641		
F0692 SS = D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration.	F0692		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255306	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 05/28/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TREND HEALTH AND REHAB OF HOUSTON	**1000 EAST MADISON STREET , HOUSTON, Mississippi, 38851**

(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
F0692 SS = D	Continued from page 3 (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is NOT MET as evidenced by: Based on observation, staff interviews, record review, and facility policy review, the facility failed to ensure a physician-ordered fluid restriction was followed for one (1) of 16 residents reviewed for hydration. Resident #1 Findings Include: Review of facility policy titled “Fluid Restriction” revealed, “Fluids will be restricted for residents as directed by physician orders…Procedure: 1. Nursing notifies the dietary department when a patient is placed on fluid restriction. 2. Nursing, the Director of Food and Nutrition Services, and the Consultant Dietitian determine the allotment of fluids among meals, medications, etc.…4. The type and amount of fluids served from the food and nutrition service department will be noted on the tray card/tray ticket. 5. Water pitchers will not be placed at bedside. 6. Nursing service will document intake and output…” Record review of Resident #1's "Medication Administration Record" with order date of 10/11/2025 revealed, "2000 ml (milliliter) fluid restriction one time a day related to Heart Failure, Unspecified; Edema, Unspecified.”	F0692		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255306	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 05/28/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TREND HEALTH AND REHAB OF HOUSTON	**1000 EAST MADISON STREET , HOUSTON, Mississippi, 38851**

(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
F0692 SS = D	Continued from page 4 On 5/26/2026 at 11:15 AM an observation revealed Resident #1 had significant edema in both lower extremities. A water pitcher was also noted on the bedside table. On 5/27/2026 at 10:59 AM, an interview with Licensed Practical Nurse (LPN) #1 confirmed that Resident #1 was on a 2000 Milliliter (ML) fluid restriction. LPN #1 stated staff does not track the resident's total fluid intake and only documents "yes" or "no" on the Medication Administration Record (MAR). LPN #1 also stated Resident #1 is offered fluids from the hydration cart and is provided approximately one-half cup at a time. On 5/27/2026 at 12:12 PM, an observation of Resident #1 in the dining room revealed Resident #1 was served eight (8) oz of milk, four (4) oz of juice, four (4) oz of Mighty Shake, and a personal cup containing an unknown amount of fluid. Review of the meal ticket showed no indication that the resident was on a fluid restriction or the number of fluids allowed with meals. On 5/27/2026 at 2:46 PM, an interview with Registered Nurse (RN) #2 confirmed that Resident #1's 24-hour fluid intake is not documented. On 5/27/2026 at 3:09 PM, an interview with the Dietary Manager revealed Resident #1 received the standard fluid amount of 1500 milliliters for meals. An interview with the Director of Nursing (DON) on 5/28/2026 at 12:15 PM confirmed an order had not been entered for nursing staff to document Resident #1's 24-hour fluid intake on the MAR. The DON acknowledged the risks associated with failing to monitor Resident #1's fluid intake would be fluid volume overload. Record review of "Admission Record" revealed Resident #1 was admitted to facility on 9/02/2025 with diagnoses including Heart Failure, unspecified and Edema, unspecified. Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 2/27/2026 revealed under section C, a Brief Interview for Mental Status (BIMS) summary score of 6, which	F0692		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255306	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 05/28/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TREND HEALTH AND REHAB OF HOUSTON	**1000 EAST MADISON STREET , HOUSTON, Mississippi, 38851**

(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
F0692 SS = D	Continued from page 5 indicated Resident #1 was severely cognitively impaired.	F0692		
F0695 SS = D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is NOT MET as evidenced by: Based on observation, record review, staff interviews, and facility policy review, the facility failed to ensure oxygen was administered in accordance with physician orders for one (1) of 25 residents receiving oxygen. Resident #14 Findings Include: Review of the facility policy titled “Oxygen Administration Policy” revealed, “Oxygen is administered to residents who need it, consistent with professional standards of practice, the comprehensive person-centered care plans, and the resident’s goals and preferences...1. Oxygen is administered under orders of a physician...” Record review of Resident #14's "Treatment Administration Record" with order date of 4/25/2025, revealed, "O2 (oxygen) at 2 (two) liters per nasal cannula continuous every shift related to Chronic Obstructive Pulmonary Disease (COPD), Unspecified." An observation on 5/26/2026 at 12:00 PM revealed Resident #14 sitting in dining room with no oxygen in place or available. On 5/26/2026 at 3:26 PM, Resident #14 was observed lying in bed with oxygen in place by nasal cannula at four (4) liters per minute. On 5/27/2026 at 10:51 AM, Resident #14 was observed lying in bed with oxygen in place by nasal cannula at three (3) and a half liters per minute. An interview on 5/27/2026 at 10:53 AM with	F0695		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255306	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 05/28/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TREND HEALTH AND REHAB OF HOUSTON	**1000 EAST MADISON STREET , HOUSTON, Mississippi, 38851**

(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
F0695 SS = D	Continued from page 6 Licensed Practical Nurse (LPN) #1 revealed Resident #14 was on continuous oxygen at two (2) liters per minute for COPD. LPN #1 confirmed the oxygen was set at three (3) and a half liter, and the physician order was not followed. She acknowledged the risks of Resident #14 not receiving oxygen as ordered. On 5/27/2026 at 11:35 AM, an interview with the Director of Nursing (DON) confirmed the physician order for oxygen administration was not followed. Record review of “Admission Record” revealed Resident #14 was admitted to facility on 9/01/2022 with medical diagnoses including Chronic Obstructive Pulmonary Disease, Unspecified. Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 2/27/2026 revealed under section C, a Brief Interview for Mental Status (BIMS) summary score of 6, which indicated Resident #14 was severely cognitively impaired.	F0695		
F0880 SS = D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:	F0880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255306	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 05/28/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TREND HEALTH AND REHAB OF HOUSTON	**1000 EAST MADISON STREET , HOUSTON, Mississippi, 38851**

(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
F0880 SS = D	Continued from page 7 (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, record review, and facility policy review, the facility failed to implement and maintain an effective infection prevention and control program to prevent the transmission of infectious diseases for staff observed performing	F0880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255306	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 05/28/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TREND HEALTH AND REHAB OF HOUSTON	**1000 EAST MADISON STREET , HOUSTON, Mississippi, 38851**

(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
F0880 SS = D	Continued from page 8 glucometer disinfection and for oxygen tubing storage (Resident #5) during two (2) of four (4) care areas observed. Findings include: Review of facility policy titled “Glucometer Control Monitoring and Cleaning,” updated 2/2016, revealed, “…The machine will be cleaned before and after each use with a multi-germicidal disinfectant wipe…The glucose monitors are to be cleaned before and after each use with a moist cloth dampened with a multi-germicidal cleaning solution…” Review of facility policy titled "Nebulizer and Oxygen Tubing Storage Policy" updated September 2025, revealed, " It is the policy of this facility to decrease the risk of potential and/or direct exposure to infectious diseases, air contaminants, and bacterial exposure. We will provide our residents with the proper storage and cleaning of respiratory equipment." During an observation on 05/27/2026 at 11:48 AM, following a blood glucose check, Licensed Practical Nurse (LPN) #1 wiped the multi-use glucometer with a Sani-Cloth Germicidal Disposable Wipe for several seconds. The glucometer was not maintained in a visibly wet state for the manufacturer's required two-minute contact time before being returned to service. When questioned regarding the disinfection process, LPN #1 stated, "I wipe the glucometer down with the wipe for 10-15 seconds and then let it dry for two (2) minutes." During an interview on 05/27/2026 at 11:49 AM, the Infection Control Nurse confirmed the glucometer should be disinfected with Sani-Cloth wipes between residents and remain wet for the required two (2) minute contact time. During an interview on 05/27/2026 at 12:21 PM, the Director of Nursing (DON) confirmed the glucometer should be disinfected after each use with a Sani-Cloth wipe and remain wet for two (2) minutes. Review of the Super Sani-Cloth Product Guide for Sani-Cloth Germicidal Disposable Wipes revealed, “Allow surface to remain wet for 2 minutes. Let air dry.” Resident #5 During an observation of resident care on	F0880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255306	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 05/28/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TREND HEALTH AND REHAB OF HOUSTON	**1000 EAST MADISON STREET , HOUSTON, Mississippi, 38851**

(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
F0880 SS = D	Continued from page 9 05/27/2026 at 2:24 PM with the Infection Control Nurse it was observed that Resident #5's oxygen (O2) tubing was lying on the floor under a fall mat in the room. During an interview on 05/27/2026 at 2:30 PM with the Infection Control Nurse, she confirmed the oxygen tubing was lying on the floor, and that this would increase his risk for infection. During an interview and observation on 05/27/2026 at 2:45 PM with the Director of Nursing (DON), she verbalized the oxygen tubing should not be on the floor, she removed the tubing from the concentrator and disposed of it. Record review of the Order Summary Report for Resident #5 revealed an order dated 3/11/25 for O2 BNC (bi-prong nasal cannula) at 2 liters per minute as needed for shortness of breath. Record review of “Admission Record” revealed Resident #5 was admitted to facility on 3/11/2022 with medical diagnoses including Cerebral Palsy and Chronic Obstructive Pulmonary Disease. Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 3/06/2026 revealed under section C, a Brief Interview for Mental Status (BIMS) summary score of 5, indicating Resident #5 was severely cognitively impaired.	F0880		