STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(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
M0000	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 Minimum Standards for Institutions for the Aged or Infirm, state licensure requirements. During the survey the SA cited M650 & M1570. The census at the time of the survey was 53 with a license for 60 beds.	M0000		
M0650	45.21.10 Hydration Hydration. Each resident shall be provided sufficient fluid intake to maintain proper hydration and health. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Level IIBased 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.” 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	M0650		

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

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M0650	Continued from page 1 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 indicated Resident #1 was severely cognitively impaired.	M0650		
M1570	48.58.1 Infection Control The following infection control standards shall be met:	M1570		

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M1570	Continued from page 2 1. The facility must maintain and document an effective infection control program that protects patients, families, visitors, and facility personnel by preventing and controlling infections and communicable diseases. 2. The facility must have an active surveillance program that includes specific measures for prevention, early detection, control, education, and investigation of infections and communicable diseases in the facility. There must be a mechanism to evaluate the effectiveness of the program(s) and take corrective action when necessary. The program must include implementation of nationally recognized systems of infection control guidelines to avoid sources and transmission of infections and communicable diseases. 3. The facility must follow accepted standards of practice to prevent the transmission of infections and communicable diseases, including the use of standard precautions. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Level IIBased 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 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."	M1570		

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M1570	Continued from page 3 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 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	M1570		

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M1570	Continued from page 4 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.	M1570		