

MSDH - Health Facilities Licensure and Certification

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| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>40CH</b>                               | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   | (X3) DATE SURVEY<br>COMPLETED<br><br><b>C</b><br><b>05/19/2022</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>TREND HEALTH &amp; REHAB OF CARTHAGE LLC</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>1101 EAST FRANKLIN STREET</b><br><b>CARTHAGE, MS 39051</b> |                                                                                                                          |                                                                    |
| (X4) ID<br>PREFIX<br>TAG                                                            | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                      | ID<br>PREFIX<br>TAG                                                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE                                           |
| M 000                                                                               | <p>Initial Comments</p> <p>The State Agency (SA) conducted a complaint survey for MS #18582, MS #18744, and MS #18749 at the facility from 5/16/22 through 5/19/22. The SA determined the facility was in compliance with the Mississippi Regulations for Minimum Standards for Institutions for Aged or Infirm related to neglect, remaining wet, resident on resident, assessment and monitoring, tube feedings, falsification of records, cardiopulmonary resuscitation.</p> <p>At the time of the survey, the facility had a census of 82 and held a license for 99 beds.</p> | M 000                                                                                                  |                                                                                                                          |                                                                    |

Mississippi State Department of Health  
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE