

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 04/08/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255162	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/10/2024
NAME OF PROVIDER OR SUPPLIER Trend Health and Rehab of Brookhaven		STREET ADDRESS, CITY, STATE, ZIP CODE 525 Brookman Drive Brookhaven, MS 39601	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Based on observation, interviews, record review, and facility policy review, the facility failed to ensure a resident's right to a clean, comfortable, and homelike environment as evidenced by a soiled privacy curtain, missing paint on the walls, strong odors, and flies present in the resident's room for one (1) of fourteen (18) sampled residents. Resident #14 Findings Include: A review of the facility's policy titled Safe and Homelike Environment, undated, revealed, .In accordance with residents' rights, the facility will provide a safe, clean, comfortable and homelike environment . A review of the facility's Residents' Rights document, undated, revealed, .You have the right to live and receive care in a residential setting that is homelike, safe, clean, and comfortable. For example, you are entitled .to housekeeping and related services to keep your living spaces clean, uncluttered, and comfortable . During an observation on 10/07/24 at 12:15 PM, Resident #14's room was observed with a strong smell of urine and mildew. There were four (4) flies flying around the resident's bed, mattress, and pillow. There was paint missing from the wall to the left of the bed, and a spider web with a fly in it was observed behind the door in the upper left-hand corner. The privacy curtain had visible food and other stains. During an interview on 10/07/24 at 1:00 PM, Resident #14 expressed significant concerns regarding her living conditions within the facility. She reported that the persistent strong odor, which she described as moldy, has led her to spend most of her time outside of her room. Resident #14 also reported that recently the presence of flies in her room had increased significantly. During an observation on 10/08/24 at 11:47 AM, in Resident #14's room, there was a strong smell of urine and mildew. Four (4) flies were flying around her bed, mattress, and pillow. The paint was still missing from the wall to the left of the bed, and the spider web was still behind the door. The privacy curtain remained soiled with visible food and other brown, discolored stains. During an observation and interview on 10/08/24 at 12:00 PM, the Facility Administrator confirmed the presence of flies, the odor of mildew, the missing paint on the wall, and the stained privacy curtain in Resident #14's room. The Administrator stated that it was the responsibility of the housekeeping supervisor to ensure the facility, especially resident rooms, was cleaned thoroughly to maintain a homelike environment. He acknowledged that the cleanliness of the resident's room had not been (continued on next page)		

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 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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: 255162	Facility ID: 255162
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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	maintained according to the facility's standards. During an observation and interview on 10/08/24 at 12:10 PM, Housekeeping Staff #1 confirmed the presence of flies, the smell of mildew, the stained privacy curtain, and the missing paint in Resident #14's room. He expressed that housekeeping staff are expected to clean resident rooms thoroughly to maintain a homelike environment. A record review of the admission Record revealed Resident #14 was admitted by the facility on 9/22/2023 with diagnoses including Overactive Bladder. A record review of the Optional State Minimum Data Set (MDS) Assessment with an Assessment Reference Date (ARD) of 8/29/24, revealed Resident #14 had a Brief Interview for Mental Status (BIMS) score of 9, which indicated her cognition was moderately impaired.		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on observation, staff interview, record review, and facility policy review, the facility failed to implement care plans interventions regarding wearing all Personal Protective Equipment (PPE) during perineal care and hand hygiene during Percutaneous Endoscopic Gastrostomy (PEG) tube care for two (2) of five (5) residents reviewed for care. Resident #24 and Resident #40. Findings Include: A review of the facility's policy titled Care Plan - Comprehensive, revised October 2016, revealed, An individualized (person-centered) comprehensive care plan that includes measurable objectives and timetables to meet the resident's medical, nursing, mental, and psychological needs is developed for each resident . Policy Interpretation and Implementation . 3. Each resident's comprehensive care plan is designed to: . f. Identify the professional services that are responsible for each element of care . Resident #24 A record review of Resident #24's comprehensive care plan revealed Focus: I am on Enhanced Barrier Precautions .because I have a PEG Tube .Interventions/Task .WASH HANDS BEFORE AND AFTER PROVIDING CARE TO RESIDENT with a dated initiated of 10/2/2024. On 10/10/24 at 9:07 AM, during an observation Licensed Practical Nurse (LPN) #3 entered Resident #24's room to perform PEG tube care and did not perform hand hygiene prior to applying gloves and providing care. During the procedure, LPN #3 had to exit the room. When she re-entered the room, once again, she did not perform hygiene prior to gloving and providing care to the resident. On 10/10/24 at 9:42 AM, during an interview, LPN #3 admitted that she was nervous, forgot to wash her hands, and recognized her actions posed infection control risks. Resident #40 A record review of Resident #40's comprehensive care plan with a date initiated of 4/2/2024 revealed Focus: I am on Enhanced Barrier Precautions .because I have a PEG tube .Interventions/Task .Staff will use PPE (gown and gloves) during high contact resident care activities. During an observation on 10/09/24 at 9:14 AM, Certified Nursing Assistant (CNA) #1 was observed providing perineal care to Resident #40 without wearing the required gown as part of the required PPE for residents on Enhanced Barrier Precautions. During an interview on 10/10/24 at 9:50 AM, CNA #1 confirmed she did not wear a gown and admitted that not wearing proper PPE could spread germs to the resident. During an interview on 10/10/24 at 11:30 AM, the Director of Nursing (DON) confirmed that both Resident #24 and #40 were on Enhanced Barrier Precautions due to a PEG tube. The DON stated that the comprehensive care plans for both residents revealed that they were on Enhanced Barrier Precautions, with interventions that revealed hand washing was required before and after providing care to the residents and staff wearing PPE (gown and gloves) during high contact resident care activities. The DON (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	stated that all staff should follow the comprehensive care plan. During an interview on 10/10/24 at 11:49 AM, LPN #5, the care plan nurse, confirmed that care plans should be followed by both nurses and CNAs and acknowledged that by not wearing a gown, as part of the requirements for Enhanced Barrier Precautions, and washing their hands before providing care to the resident, staff did not follow the care plan when they provided high-contact care for these two (2) residents.		

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F 0800 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs. Based on observation, interviews, record review, and facility policy review, the facility failed to ensure a resident received a physician-ordered salad during the lunch meal for one (1) of eighteen (18) sampled residents. Resident #44 Findings Include: A review of the facility's policy titled Dining and Food Preferences, revised 10/2022, revealed: Individual dining, food, and beverage preferences are identified for all residents/patients. During an interview on 10/07/24 at 10:43 AM, Resident #44 stated that the kitchen does not provide her with food to her liking. She mentioned that she enjoys eating salads daily but has not received them in several months, despite requesting them through the nurses and Certified Nursing Assistants (CNAs). She added that she stopped asking because she became tired of repeating her request. During an observation on 10/07/24 at 12:31 PM, it was noted that Resident #44's lunch tray did not contain a salad. During an interview on 10/07/24 at 2:13 PM, Resident #44's sister expressed her frustration with the facility's failure to honor her sister's food preferences, specifically her desire to receive salads with meals. During an interview on 10/08/24 at 12:11 PM, the Dietary Manager stated that she collects resident food preferences upon admission but had not updated Resident #44's preferences in a while. She acknowledged that it was probably time to reassess the resident's preferences. During an observation on 10/08/24 at 12:17 PM, Resident #44's lunch tray again did not contain a salad. During a follow-up interview on 10/09/24 at 7:02 AM, the Dietary Manager admitted that she stopped purchasing salads a few months ago because of cost concerns. She also revealed that she was unaware of the physician's order requesting that Resident #44 receive a side salad with ranch at every lunch meal. The Dietary Manager stated that she had not received communication from nursing staff about the order. During an interview on 10/09/24 at 2:21 PM, the Director of Nursing (DON) confirmed that the Dietary Department had been notified of the doctor's order. The DON provided a copy of the diet requisition form, which included instructions for diet changes. During an interview on 10/10/24 at 9:21 AM, the Registered Dietician (RD) explained that with every nutritional assessment and recommendation for a resident, she emails a copy to the doctor, DON, and Dietary Manager. She also provides each of them with a hard copy of the diet requisition form, which indicates the same information included in the assessment. A record review of the admission Record revealed that the facility admitted Resident #44 on 11/22/23 with diagnoses including Hyperlipidemia and Type 2 Diabetes. (continued on next page)		

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F 0800 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A record review of the Quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 09/12/24, revealed Resident #44 had a Brief Interview for Mental Status (BIMS) score of fifteen (15), indicating she was cognitively intact. A record review of the electronic health record Care Profile revealed Resident #44 had an active physician's order, with a start date of 3/19/24, Provide House side salad with Ranch dressing on lunch tray daily . A record review of Resident #44'sRD Assessment & Recommendations, dated 3/13/24, revealed, .Request side salad w/(with) ranch on lunch tray. Will inform dietary . A record review of the Diet Requisition Form, dated 3/18/24, revealed a Request for Services to provide side salad w/ranch on lunch tray daily . The form indicated the requisition was for Resident #44.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on observation, interviews, record reviews, and facility policy review, the facility failed to ensure proper infection control practices during the provision of care for residents on Enhanced Barrier Precautions (EBP) for two (2) of five (5) care observations. Residents #24 and #40. Findings Include: A review of the facility's procedure titled Procedure for Handwashing, revised 04/15, revealed .When to Wash Hands (at a minimum) . Before and after each resident content After handling any contaminated items (linens, soiled diapers, garbage, etc.) A review of the facility's policy titled, Enhanced Barrier Precautions revised 08/07/24, revealed It is the policy of this facility to implement enhanced barrier precautions for the prevention of transmission of multidrug-resistant organism. Definitions: Enhanced barrier precautions (EBP) refer to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and gloves use during high contact resident care activities . A review of the facility's policy titled Infection Prevention and Control Program, (undated) revealed It is a policy of this facility to 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 . Resident #24 During an observation on 10/10/24 at 9:07 AM, Licensed Practical Nurse (LPN) #3 entered Resident #24's room to perform PEG tube care and did not perform hand hygiene prior to applying gloves and providing care. During the procedure, the supplies needed for continuation of care fell off the bedside table onto the floor. LPN #3 picked up the dirty supplies, and threw them away, however, when she re-entered the resident's room after securing additional supplies, once again, she did not perform hand hygiene prior to applying her gloves. During an interview on 10/10/24 at 9:41 AM, LPN #3 confirmed she forgot to wash her hands upon entering the room prior to applying gloves and beginning care. The nurse admitted that her actions was against infection control guidelines and could pose a risk for infection. A record review of Resident #24's Order Summary Report, with active orders as of 10/10/24, revealed orders, dated 05/20/24, to clean around the PEG tube site with normal saline gauze, pat dry, apply gentamycin ointment around the stoma, cover with split gauze, and secure with tape twice daily for a gastrostomy infection, until resolved, then discontinue. There was also an order, dated 04/08/24, for Enhanced Barrier Precautions related to PEG tube every day and night shift. A record review of Resident #24's admission Record revealed the facility admitted the resident on 12/11/19. The resident had diagnoses that included Unspecified Sequelae of Unspecified Cerebrovascular Disease, Epilepsy, and Dysphagia. A record review of the Annual Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 08/27/24 revealed that Resident #24's cognitive skills was severely impaired. Section K indicated the presence of a feeding tube. (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #40 During an observation on 10/09/24 at 9:14 AM, Certified Nursing Assistant (CNA) #1 provided peri care to Resident #40 without wearing the required gown, which was part of the Enhanced Barrier Precautions. During an interview on 10/10/24 at 9:50 AM, CNA #1 confirmed she did not wear the gown as required and acknowledged that not wearing proper PPE could result in the transmission of germs to the resident and others. During an interview on 10/10/24 at 11:23 AM, the Director of Nursing (DON) confirmed that hand hygiene before resident care and when a nurse changes gloves is an important part of infection control. The DON also confirmed that CNA #1 should have worn a gown when providing care to Resident #40, as that is a requirement for Enhanced Barrier Precautions to prevent the risk of cross-contamination. During an interview on 10/10/24 at 11:33 AM, LPN #4 (Infection Preventionist) stated that LPN #3 should have performed hand hygiene prior to providing resident care and when changing gloves. LPN #4 also confirmed that CNA #1 should have worn the required gown while performing care for Resident #40 to decrease the risk of germs being transferred to the CNA's uniform, which could for cross contamination, while providing care to other residents. A record review of Resident #40's Order Summary Report, with active orders as of 10/10/24, revealed an order, dated 04/08/24, for Enhanced Barrier Precautions related to the resident's PEG tube. A record review of Resident #40's admission Record revealed the facility admitted the resident on 01/23/24. The resident's diagnoses included Alzheimer's Disease, Vascular Dementia, and Dysphagia. A record review of the Quarterly MDS with an ARD of 07/25/24 revealed that Resident #40 was unable to complete the Brief Interview for Mental Status (BIMS) for cognitive status and was scored 99 on the assessment.		