STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255326	A. BUILDING _____ B. WING _____	C 01/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINE FOREST HEALTH AND REHABILITATION	1116 FOREST AVENUE JACKSON, MS 39206

(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
F 000	INITIAL COMMENTS The State Agency (SA) conducted five (5) Complaint Investigations (CI MS #27324, CI MS #27388, CI MS #27404, CI MS #27635, and CI MS #27658) at the facility, from 1/15/25 through 1/17/25. During the survey, the SA determined the facility was not in compliance with the requirements for participation in Medicare and Medicaid. CI MS #27324 was investigated related to neglect, and Quality of Care/Treatment regarding resident not turned/repositioned and F558 was cited. CI MS #27388 was investigated regarding Physical Environment related to lack of adequate linens, Resident Neglect and Quality of Care related to unresolved grievances, and F585 was cited. CI MS #27404 was investigated related to Accidents/Falls, Quality of Care/Treatment related to resident safety/falls, the Resident Representative not notified and Physical Environment related to equipment not maintained and F689 was cited. CI MS #27635 was investigated regarding Resident Nursing Services and Quality of Care/Treatment related to unresolved grievances. CI MS #27658 was investigated related to Resident Neglect and Quality of Care/Treatment related to resident medications not given according to physician instructions. There were no deficiencies cited related to CI MS# 27635 or CI MS #27658. The facility held a license for 120 beds, with a census of 100.	F 000		
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and	F 558		2/28/25

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

Electronically Signed | 02/05/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255326	A. BUILDING _____ B. WING _____	C 01/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINE FOREST HEALTH AND REHABILITATION	1116 FOREST AVENUE JACKSON, MS 39206

(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
F 558	Continued From page 1	F 558		

preferences except when to do so would endanger the health or safety of the resident or other residents.
This REQUIREMENT is not met as evidenced by:
Based on observation, interviews, and record review, the facility policy review, the facility failed to ensure the call lights were within reach for two (2) of seven (7) residents, Resident #3 and Resident #6.

Findings Included:

A review of the facility policy titled "Call Light Standard", dated 03/2019, revealed, " ...The purpose of this standard is to assure the facility is adequately equipped with a call light at each residents' bedside, toilet, and bathing facility to allow residents to call for assistance ...Policy Explanation and Compliance Guidelines ...5. With each interaction in the resident's room or bathroom, staff will ensure the call light is within reach of resident and secured, as needed ..."

Resident #3

On 1/15/25 at 6:13 AM, an observation and interview revealed Resident #3 was awake and resting in bed. The resident's call light was on the floor by her bed. She stated that she could use her call light but did not know where it was.

A record review of the "Admission Record" revealed the facility initially admitted Resident #3 on 11/18/22 and her most recent admission date was 11/01/24. She had current diagnoses including Cerebral Infarction.

A record review of the Quarterly Minimum Data

1. The call lights for Resident #3 and Resident #6 were disinfected and immediately placed within resident□s reach on 1/15/2025. A 100% audit was completed by Director of Nursing on 1/15/2025 to ensure that all resident□s call lights were within reach to accommodate resident□s needs/preferences.

2. The facility has determined that all residents have the potential to be affected.

3. On 1/16/25, the Maintenance Director completed a 100% audit of call light clips for inspection. Any missing call light clips were replaced immediately to ensure call lights can be clipped within resident□s reach to accommodate needs/preferences. Nurse Educator provided in-service education on 1/21/25 for staff personnel addressing policies, procedures, regulations and facility expectations of staff to assure the accessibility of call lights in resident rooms at all times. Policy was reviewed on 1/28/25 by Quality Assurance Performance Improvement Committee and no changes were made. Monitoring will continue until 2/28/2025.

4. Nurse Educator or License Nurse will make rounds 2 times daily for 4 weeks;

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255326	A. BUILDING _____ B. WING _____	C 01/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINE FOREST HEALTH AND REHABILITATION	1116 FOREST AVENUE JACKSON, MS 39206

(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
F 558	Continued From page 2	F 558		

Set (MDS) with an Assessment Reference Date (ARD) of 12/17/24 revealed Resident #3 had a Brief Interview for Mental Status (BIMS) score of 6, indicating severe cognitive impairment. Further review revealed Resident #3 was dependent upon staff for all activities of daily living (ADLs).

Resident #6

On 1/15/25 at 5:05 PM, observation revealed that Resident #6 was resting in bed with the call light coiled up on the floor at the end of her bed, out of her reach. The Director of Nurses (DON) retrieved the call light and placed it within reach of the resident.

A record review of the "Admission Record" revealed the facility admitted Resident #6 on 11/14/24 with current diagnoses including Chronic Obstructive Pulmonary Disease.

A record review of the Admission MDS with an ARD of 11/21/24 for Resident #6 revealed the resident had a BIMS score of 7, indicating severe cognitive impairment. Section GG revealed the resident required staff assistance for ADLs.

On 1/15/25 at 6:50 AM, an interview with Certified Nurse Aide (CNA) #1 she reported call lights were to be within the reach of residents.

On 1/15/25 at 6:58 AM, an interview with CNA #2 confirmed that call lights were to be within the reach of residents.

On 1/15/25 at 11:50 AM, an interview with Licensed Practical Nurse (LPN)#2 revealed that staff made rounds throughout the day and nurses made rounds to ensure that residents received

then daily for 4 weeks beginning 1/20/2025. Director of Nursing will complete rounds 3 times a week for two additional weeks to ensure compliance. This plan of correction will be monitored at the monthly Quality Assurance Performance Improvement meeting beginning 2/18/25 for two months.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255326	A. BUILDING _____ B. WING _____	C 01/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINE FOREST HEALTH AND REHABILITATION	1116 FOREST AVENUE JACKSON, MS 39206

(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
F 558	Continued From page 3 care in a timely manner. She stated that ensuring call lights were within reach of residents was necessary to ensure timely responses. On 1/17/25 at 1:12 PM, an interview with the DON revealed that she expected call lights to be left within reach of residents and answered in a timely manner. On 1/17/25 at 4:10 PM, an interview with the Administrator revealed that he expected call lights to be left within reach of residents and answered in a timely manner.	F 558		
F 585 SS=D	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	F 585		2/28/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255326	A. BUILDING _____ B. WING _____	C 01/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINE FOREST HEALTH AND REHABILITATION	1116 FOREST AVENUE JACKSON, MS 39206

(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
F 585	Continued From page 4	F 585		

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:
(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;

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255326	A. BUILDING _____ B. WING _____	C 01/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINE FOREST HEALTH AND REHABILITATION	1116 FOREST AVENUE JACKSON, MS 39206

(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
F 585	Continued From page 5 (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 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 interviews, record review, and facility policy review, the facility failed to acknowledge grievances, make prompt efforts to resolve grievances, and communicate progress toward resolution with families and residents for two (2) of seven (7) sampled residents. Resident #2 and Resident #3	F 585	1. On 1/17/25, a past grievance that was not addressed in a timely manner was confirmed by Resident #2 Family. On 1/17/25 Social Worker confirmed a grievance that was not followed up in a timely manner was confirmed by the family of Resident #2. Administration appointed Social Service to complete an	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255326	A. BUILDING _____ B. WING _____	C 01/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINE FOREST HEALTH AND REHABILITATION	1116 FOREST AVENUE JACKSON, MS 39206

(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
F 585	Continued From page 6 Findings Included: A review of the facility's policy titled "Resident & Family Grievances", revised 1/2025, revealed " ...Definitions: ; "Prompt efforts to resolve" include facility acknowledgment of a complaint/grievance and actively working toward resolution of that complaint/grievance. Procedure 1. The Administrator is ultimately responsible for the Grievance Program. Social Service staff has been designated as the Grievance Official ...8. Grievances may be voiced in the following forums: a. Verbal complaint to a staff member of Grievance Official ...d. Verbal complaint during resident or family council meetings ...10. The staff member receiving the grievance will record the nature and specifics of the grievance on the designated grievance form or assist the resident to complete the form ...c. Forward the grievance form to the Grievance Official as soon as practicable. d. The Grievance Official will take steps to resolve the grievance, and record information about the grievance, and those actions, on the grievance form ...ii ...'Prompt efforts' include acknowledgment of complaint/grievances and actively working toward a resolution of that complaint/grievance ...e. The Grievance Official, or designee, will keep the resident appropriately apprised of progress towards resolution of the grievances ..." A record review of a blank "Grievance/Concern/Comment Report" indicated an area in which the "Date and time that findings and action plan were shared with concerned party" and should be completed. A record review of the posted notification titled "RIGHT TO FILE GRIEVANCES AND	F 585	official grievance form on 1/17/25 addressing concerns of both resident#2 and resident #3. Facility resolved both grievances on 1/20/2025 and provided feedback to residents and family #2 and resident and family #3. 2. The facility has determined that all residents have the potential to be affected by the deficient practice of not resolving grievances in a timely manner. 3. The Administrator, Director of Nursing, Nurse Educator and Social Service were in-service on 1/17/25 by the Corporate Compliance Officer on the facility□s standard, Grievance Concern Comment Standard. On 1/20/25, Nurse Educator in-serviced Interdisciplinary Team on Grievance standard and procedures. Policy and standards were reviewed on 1/20/25 and no changes were made by Quality Assurance Performance Improvement committee. All grievances will be reviewed by Social Service for thorough follow-up and signed by the Administrator within 14 days. 4. Social Service will conduct four resident interviews weekly for 30 days beginning 1/27/25 and then monthly for two months to ensure compliance with the Grievance Concern Comment Standard. Any concerns noted will be immediately reported to the Administrator for evaluation and correction in compliance with reporting requirements. Grievance Log will be reviewed monthly during Quality Assurance(QA) Performance	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255326	A. BUILDING _____ B. WING _____	C 01/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINE FOREST HEALTH AND REHABILITATION	1116 FOREST AVENUE JACKSON, MS 39206

(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
F 585	Continued From page 7 COMPLAINTS", dated 2025, revealed "It is the policy of the facility to support each Resident's right to voice concerns and to ensure that after a concern has been received, the facility will actively resolve the issue and communicate the resolution's progress to the Resident and/or Resident's family in a prompt manner ...All concerns and issues are investigated, resolved, and documented." Resident #2 On 1/15/25 at 6:29 AM, an interview with Resident #2 , he stated that he had concerns in December 2024, which he had reported to facility administration, and they had not been adequately addressed until he reported them to his family. On 1/17/25 at 12:25 PM, during a telephone interview, the family member of Resident #2 reported that she requested and attended a care conference with Social Worker (SW) #1 to discuss concerns and voice grievances that the resident had already reported to staff without resolution. She stated that she considered this officially filing a grievance and stated that she was not sure what the facility considered an official grievance. Record review of the "Admission Record" for revealed the facility admitted Resident #2 on 2/28/24 (initial admission date 9/12/23) and the resident had diagnoses including Paraplegia. Record review of the Quarterly Minimum Data Set (MDS) with Assessment Reference Date (ARD) 12/19/24 for Resident #2 revealed the resident had a Brief Interview for Mental Status (BIMS) score of 15, which indicated no cognitive	F 585	Improvement Committee meeting for 2 months beginning 2/18/25. Adverse findings will be immediately addressed by the Quality Assurance Performance Improvement Committee.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255326	A. BUILDING _____ B. WING _____	C 01/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINE FOREST HEALTH AND REHABILITATION	1116 FOREST AVENUE JACKSON, MS 39206

(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
F 585	Continued From page 8	F 585		

impairment.

Resident #3

On 1/15/25 at 4:10 PM, during an interview the facility Social Worker (SW) #1 confirmed that she had received concerns/grievances from the family of Resident #3 which included linens, the resident left wet, food on clothes/bedding, falls and other things.

On 1/16/25 at 12:30 PM, during a telephone interview, a family member of Resident #3 revealed the family was concerned regarding the quality of care provided for Resident #3. The family members stated they had spoken with staff multiple times, including the Assistant Director of Nursing (ADON), the Director of Nursing (DON), Administrator, and Social Worker #1, with repeated concerns of the same nature on and prior to 12/02/24 to file grievances but had not received any follow-up. They stated they had called the facility several times and eventually gave up.

During a post exit interview on 1/20/25 at 2:59 PM, the Resident Representative (RR) for Resident #3 stated that she had reported grievances to SW #1 on 12/02/24 and 12/17/24 and to the ADON on 1/03/25. SW #1 asked if she wanted to file a formal grievance related to her concerns, and she acknowledged that she would like to file formal grievances. She also reported concerns during a care plan meeting on 10/1/24. She stated that she felt the staff should have recognized complaints accompanied by requests for meetings with department heads, Social Worker, DON and/or Administrator as grievances. She stated that her most pressing concern was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255326	A. BUILDING _____ B. WING _____	C 01/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINE FOREST HEALTH AND REHABILITATION	1116 FOREST AVENUE JACKSON, MS 39206

(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
F 585	Continued From page 9	F 585		

the lack of communication and follow-up on her reported concerns.

A record review of the "Care Plan Meeting: Telephone Notification" for Resident #3, dated 10/11/24, revealed no concerns, complaints, issues, or grievances voiced by the RR of Resident #3, who attended by telephone, which contradicts the RR's statement.

Record review of the "Admission Record" for Resident #3, revealed the facility admitted the resident on 11/01/24 (Initial Admission Date 11/18/22) and the resident had diagnoses of Cerebral Infarction (stroke).

Record review of the Quarterly MDS with an ARD 12/17/24 for Resident #3 revealed the resident had a BIMS score of 6, which indicated severe cognitive impairment.

A record review of the Grievance Logs for October through December 2024 revealed no grievances documented other than missing items.

A record review of the "Resident Council Meeting," dated 12/10/24 revealed, " ...Dietary - The temperature of the food upon arriving from dining hall was notably cold, which affected the overall resident experience.

A record review of the "Resident's Council Meeting Department Concerns", revealed "Resident council was held 1/14/25 at 3:00pm ...Dietary: Unresolved - Temperature of Food ..."

On 1/15/25 at 4:10 PM, an interview with SW #1 confirmed that she had received concerns/grievances from the family of Resident

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255326	A. BUILDING _____ B. WING _____	C 01/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINE FOREST HEALTH AND REHABILITATION	1116 FOREST AVENUE JACKSON, MS 39206

(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
F 585	Continued From page 10	F 585		

#3, including issues related to linens, the resident being left wet, food on clothes and bedding, falls, and "other things." She stated that she had made rounds on the resident daily and had observed the resident without linens. She stated that after being made aware of the issue of food on the resident's clothes following meals, she had observed some episodes of food on her clothes and discussed the concern with the nursing staff. She stated that she had not considered these concerns as grievances and confirmed that they were not listed on the Grievance Logs. She said, "If it's a nursing issue, I usually address it with nursing staff, unless the family stated that they wanted to file an official grievance, or nursing submitted a concern in writing." She stated that she expected nursing to call and follow up with the resident but was aware that the family or person reporting concerns were not always contacted to confirm whether the nursing staff had followed up. She stated that if a family filed a grievance, she had fourteen days to address the concerns and respond with results to the RR, family, or person filing the grievance. She stated that grievances were to be logged on a monthly Grievance Log and that the monthly logs were not just for missing items, even though the only entries in the logs for October through December 2024 listed only missing items. She stated that she was involved in Resident Council Meetings and that concerns raised in Resident Council were not treated as grievances. She stated that voicemail's left by family were addressed immediately, with the appropriate department notified and a response given to the family, who could then opt to make an official grievance or not. She confirmed that she had received calls from the family of Resident #3, during which concerns were discussed, and care conferences

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255326	A. BUILDING _____ B. WING _____	C 01/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINE FOREST HEALTH AND REHABILITATION	1116 FOREST AVENUE JACKSON, MS 39206

(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
F 585	Continued From page 11	F 585		

were requested, but she did not consider their calls and requests to speak with her and/or department supervisors as grievances.

On 1/17/25 at 11:15 AM, a telephone interview with the facility Ombudsman revealed she reported that the facility management had not provided follow-up for concerns/grievances she had presented on behalf of the residents or on observations she had made and reported regarding resident care. She stated she was unsure of the facility's specific grievance policy but that the concerns she had reported and complaints by residents had gone unresolved, with no follow-up or resolution report.

On 1/17/25 at 3:15 PM, an interview with Social Workers revealed that Social Worker #2 said she participated the Resident Council meeting on 1/14/25. She stated that she was "still learning" facility policy and procedure for Grievances. Social Worker #1 stated that she had fourteen days to document grievances, report them to the appropriate department supervisors and either follow up with the party that reported the grievance or confirm that the department supervisor had followed up.

On 1/17/25 at 3:20 PM, an interview with the Resident Council President, he stated that he did not feel like the facility made efforts to resolve grievances raised in the council meetings. He confirmed that grievances voiced during the December 2024 meeting were unresolved as of the January 2025 meeting.

On 1/17/25 at 3:25 PM, an interview with the Activity Director revealed that she arranged monthly resident council meetings, documented

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255326	A. BUILDING _____ B. WING _____	C 01/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINE FOREST HEALTH AND REHABILITATION	1116 FOREST AVENUE JACKSON, MS 39206

(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
F 585	Continued From page 12 minutes, and presented concerns/complaints/grievances to the Interdisciplinary Team (IDT). She stated that department supervisors were responsible for addressing concerns/complaints/grievances. She stated that all concerns/complaints/grievances from each month were addressed at the following month's meeting to determine which had been resolved or remained unresolved. On 1/17/25 at 4:10 PM, an interview with the Administrator revealed that the facility had a policy and procedure in place to receive, document, resolve, and follow up on complaints/grievances and that he was the facility Grievance Officer, along with the Social Workers. He said he supported the residents' and families' rights to voice concerns and receive follow-up on those concerns. He stated, "The system is in place; I feel we need to be sure to document more regarding progress and plans for addressing concerns and following up." He stated that he would consider a resident or family request for a care conference with department heads to voice concerns as a complaint or grievance, which should be documented and followed up on. He stated that staff were trying to improve communication and documentation in the grievance process and the facility might not be following up consistently on concerns and grievances. Regarding the Resident Council Minutes, he said that they should be presented to the appropriate department with the expectation that the issues be addressed.	F 585		
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents.	F 689		2/28/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255326	A. BUILDING _____ B. WING _____	C 01/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINE FOREST HEALTH AND REHABILITATION	1116 FOREST AVENUE JACKSON, MS 39206

(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
F 689	Continued From page 13 The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on interviews, record review, and facility policy review, the facility failed to secure a resident in a mechanical lift and maintain necessary supervision during a transfer resulting in a laceration requiring staples and Emergency Department (ED) visit for one (1) of seven (7) sampled residents. Resident #1 Findings included: Review of the facility's policy, "Transferring Clients with a Mechanical Lift," undated, revealed "Read the manufacturer's instructions on: How to properly operate the lift ...Promotes safety" and "To operate the lift for transfer from the bed to a chair/wheelchair: Follow the manufacturer's instructions to operate the lift ...Promotes safety". Record review of the Incident Report dated 12/21/24 5:10 AM prepared by Licensed Practical Nurse (LPN) #1, revealed " Incident Description: UPON NURSE ENTERING ROOM, RESIDENT BODY SLANTED SLIGHTLY UNDER BED BUT MOSTLY ON FLOOR BUT HER LEGS REMAINED OVER BOTTOM OF LIFT AND BACK OF HEAD ALSO ON LIFT WITH MODERATE AMOUNT OF BLOOD NOTED ON LIFT AND FLOOR ... RESIDENT'S RP(Responsible Party) IS (RP name). CONTACTED HER AND NOTIFIED HER OF	F 689	1. On 12/21/24, the facility failed to secure Resident #1 in a mechanical lift and maintain necessary supervision during a transfer resulting in a fall. Resident #1 was transferred to Emergency Room. Fall investigation initiated on 12/21/2024 by Director of Nursing. 2. The facility has determined that this deficient practice has the potential to affect residents that require the use of a mechanical lift for mobility. 3. Director of Nursing and Nurse Educator completed one on one competency education on 12/23/24 to Certified Nursing Assistant #3 on Transferring residents with a mechanical lift. Nurse Educator conducted an In-service with scheduled Certified Nursing Assistants on how to properly use the mechanical lift on 12/23/24 and for all Certified Nursing Assistants on 12/26/24. Lift competency was assigned to all Certified Nursing Assistant on 12/26/24 in Relias. Lift competencies completed on 12/30/2024. All residents lift assessments were updated and revised as needed on 1/24/25. Minimum Data Set team (MDS)	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255326	A. BUILDING _____ B. WING _____	C 01/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINE FOREST HEALTH AND REHABILITATION	1116 FOREST AVENUE JACKSON, MS 39206

(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
F 689	Continued From page 14 RESIDENT'S FALL AND THAT SHE WAS BEING TRANSFERRED TO (specific) HOSPITAL WHICH SHE STATED WAS HER REQUEST TO BE EVALUATED. THANKED THIS WRITER FOR CALLING. RESIDENT LEFT FACILITY AT 545 AM VIA STRETCHER PER (ambulance service) ...RESIDENT REMAINED ALERT ...BLEEDING NOTED FROM BACK OF HEAD...Other Info revealed, " ...CNA (Certified Nurse Aide) stated that she was getting resident ready to get her up. Stated she went back into room and proceeded to lift her up in the air over the bed while waiting for the other CNA to come help. Stated she noticed resident was sliding out the lift pad from the top of the left and by the time she caught this and could let her down onto the bed she had already came out of the lift pad onto the floor." Record review of the Owner's Manual for the (Proper Name of Mechanical Lift), copyright 2021, revealed, " ...Safety Warnings & (and) Cautions...Lift Operation ...WARNING: More than one assistant is recommended for all resident lift activities..." A record review of the "Instructions" from the acute hospital documentation, dated 12/21/2024, revealed "You (Resident #1) were seen in the ED after a fall ...There are two (2) staples to the back of your scalp ..." Record review of the Admission Record for Resident #1 revealed the facility admitted the resident on 01/22/24 and the resident had diagnoses of Paraplegia, complete. Record review of the Admission Minimum Data Set (MDS) for Resident #1 with Assessment Reference Date (ARD) 12/27/24 revealed the	F 689	completed 100% audit to ensure resident□s Individual Care Service Plan (ICSP) was updated to ensure certified nursing assistants (CNAs) know what lift is required with residents. Maintenance inspected all lifts and slings for safety on 1/20/25. 4. Nursing Administration will review new admissions as of 1/1/2025 and 4 select residents that uses mechanical lift records weekly for 2 months to ensure resident□s lift evaluation are complete to determine what lift is required. Nurse Educator will administer in-person mechanical lift competency skill check off once to each scheduled CNAs for 4 weeks starting 1/20/25. The Nursing Administration will observe 4 CNAs Transfer 2 times weekly with a mechanical lift checkoffs utilizing a validation checklist for 2 months beginning 1/27/25. The findings will be reviewed monthly during Quality Assurance Performance Improvement Committee beginning 2/18/25 for two months.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255326	A. BUILDING _____ B. WING _____	C 01/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINE FOREST HEALTH AND REHABILITATION	1116 FOREST AVENUE JACKSON, MS 39206

(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
F 689	Continued From page 15	F 689		

resident had a Brief Interview for Mental Status (BIMS) score of 11, which indicated moderate cognitive impairment. Section GG revealed Resident #1 was not ambulatory and was dependent for bed to chair transfers.

On 1/15/25 at 9:42 AM, during a telephone interview CNA #3 reported she was assigned to the care of Resident #1 on the morning of 12/21/24 between 5:00 AM and 6:00 AM and that following Activities of Daily Living (ADL) care she positioned the mechanical lift and elevated the resident above the mattress on her bed. She stated she was waiting for assistance with the transfer and that while the resident was in the lift sling, elevated above the mattress she went to the door of the resident's room to call for assistance and turned back to see the resident sliding out of the sling. She stated that she was unable to stop the resident from falling and the resident landed on the mattress and then slid off the mattress to the floor and landed with her legs on the left base of the lift and her head on the right base of the lift. She said LPN #1 came and conducted a body audit which revealed the back of the resident's head was bleeding. CNA #3 stated that the facility had provided in-service training for use of the floor lift and required return demonstration for safe use via competency checkoffs. She stated that the training she received included the participation of two staff members for bed to wheelchair transfers for dependent residents with the floor lift. She confirmed that when she left the resident and walked to the room door to summon second staff member for assistance the resident was elevated above the mattress in the sling, therefore left unattended. She stated that there was nothing wrong with the lift or the sling. She confirmed that

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255326	A. BUILDING _____ B. WING _____	C 01/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINE FOREST HEALTH AND REHABILITATION	1116 FOREST AVENUE JACKSON, MS 39206

(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
F 689	Continued From page 16	F 689		

there were other staff available for assistance but that she was the only staff in the resident's room at the time of the fall.

On 1/15/25 at 11:50 AM, during an interview with LPN #2, who is the facility's Staff Educator, revealed CNAs were trained to use the mechanical lifts using video, demonstration and competency checkoffs during orientation upon hire and on-going. She stated that she encouraged the employment of at least two (2) staff for surface-to-surface transfers for dependent residents according to the lift owner's manual and emphasized safety precautions such as never leaving a resident suspended from a lift unattended.

On 1/17/25 at 3:55 PM, during an interview the Director of Nursing (DON) confirmed that she had participated in an investigation following Resident #1's fall with injury on 12/21/24 and determined the cause of the fall was that CNA #3 failed to ensure that she had adequate staff present for a safe transfer.

On 1/17/25 at 4:10 PM, during an interview the Administrator revealed that regarding provision of safety measures related to falls/accidents/incidents, he stated, "Our ultimate goal is to safeguard our residents.".