STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25CG	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) COMPLETE DATE
M 000	Initial Comments The State Agency (SA) conducted Complaint Investigations (CIs), at the facility, from 1/15/25 through 1/17/25. During the survey, SA determined the facility was not in compliance with the Minimum Standards for Institutions for the Aged or Infirm, state licensure requirements. 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 M500 was cited. CI MS #27404 was investigated related to Accidents/Falls, Quality of Care/Treatment related to resident safety/falls and Resident Representative (RR) not notified and Physical Environment related to equipment not maintained and M640 was cited. CI MS #27324 was investigated related to neglect, and Quality of Care/Treatment regarding resident not turned/repositioned. 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# 27324, CI MS#27635 or CI MS #27658.	M 000		
M 500	45.17.2 Residents' Rights Residents' Rights. The residents' rights policies and procedures ensure that each resident admitted to the facility: 1. is fully informed, as evidenced by the resident's written acknowledgment, prior to or at the time of admission and during stay, of these rights and is given a statement of the facility's rules and	M 500		2/28/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25CG	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) COMPLETE DATE
M 500	Continued From page 1	M 500		

regulations and an explanation of the resident's responsibility to obey all reasonable regulations of the facility and to respect the personal rights and private property of other residents;

2. is fully informed, and is given a written statement prior to or at time of admission and during stay, of services available in the facility, and of related charges including any charges for services covered by the facility's basic per diem rate;

3. is assured of adequate and appropriate medical care, is fully informed by a physician or nurse practitioner/physician assistant of his medical conditions unless medically contraindicated (as documented by a physician or nurse practitioner/physician assistant in his medical record), is afforded the opportunity to participate in the planning of his medical treatment, to not be limited in his/her choice of a pharmacy or pharmacist provider in accordance with state law, as referenced in House Bill 1439, which states that the facility shall not limit a resident ' s choice of pharmacy or pharmacy provider if that provider meets the same standards of dispensing guidelines required of long term care facilities, to refuse to participate in experimental research, and to refuse medication and treatment after fully informed of and understanding the consequences of such action;

4. is transferred or discharged only for medical reasons, or for his welfare or that of other residents, or for nonpayment for his stay (except as prohibited by sources of third-party payment), and is given a two weeks advance notice in writing to ensure orderly transfer or discharge. A copy of this notice is maintained in his medical

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25CG	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) COMPLETE DATE
M 500	Continued From page 2 record; 5. is encouraged and assisted, throughout his period of stay, to exercise his rights as a resident and as a citizen, and to this end may voice grievances, has a right of action for damages or other relief for deprivations or infringements of his right to adequate and proper treatment and care established by an applicable statute, rule, regulation or contract, and to recommend changes in policies and services to facility staff and/or to outside representatives of his choice, free from restraint, interference, coercion, discrimination, or reprisal; 6. may manage his personal financial affairs, or is given at least a quarterly accounting of financial transactions made on his behalf should the facility accept his written delegation of this responsibility to the facility for any period of time in conformance with State law; 7. is free from mental and physical abuse; 8. is free from restraint except by order of a physician or nurse practitioner/physician assistant, or unless it is determined that the resident is a threat to himself or to others. Physical and chemical restraints shall be used for medical conditions that warrant the use of a restraint. Restraint is not to be used for discipline or staff convenience. The facility must have policies and procedures addressing the use and monitoring of restraint. A physician order for restraint must be countersigned within 24 hours of the emergency application of the restraint; 9. is assured security in storing personal possessions and confidential treatment of his personal and medical records, and may approve or refuse their release to any individual outside	M 500		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25CG	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) COMPLETE DATE
M 500	Continued From page 3 the facility, except, in the case of his transfer to another health care institution, or as required by law of third-party payment contract; 10. is treated with consideration, respect, and full recognition of his dignity and individuality, including privacy in treatment and in care for his personal needs; 11. is not required to perform services for the facility that are not included for therapeutic purposes in his plan of care; 12. may associate and communicate privately with persons of his choice, may join with other residents or individuals within or outside of the facility to work for improvements in resident care, and send and receive his personal mail unopened, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 13. may meet with, and participate in activities of, social, religious and community groups at his discretion, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 14. may retain and use his personal clothing and possessions as space permits, unless to do so would infringe upon rights of other residents, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 15. if married, is assured privacy for visits by his/her spouse; if both are inpatients in the	M 500		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25CG	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) COMPLETE DATE
M 500	Continued From page 4 facility, they are permitted to share a room, unless medically contraindicated (as documented by the attending physician or nurse practitioner/physician assistant in the medical record); and 16. is assured of exercising his civil and religious liberties including the right to independent personal decisions and knowledge of available choice. The facility shall encourage and assist in the fullest exercise of these rights. This Statute is not met as evidenced by: Level II Based on observation, interviews, and record review, the facility policy review, the facility failed to ensure the call lights were within reach (Resident #3 and Resident #6) and failed to acknowledge grievances, make prompt efforts to resolve grievances, and communicate progress toward resolution with families and residents (Resident #2 and Resident #3) for three (3) of seven (7) sampled residents. Findings Included: Accommodation of Needs: 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 ..."	M 500	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. 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 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. The facility has determined that all	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25CG	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) COMPLETE DATE
M 500	Continued From page 5 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 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	M 500	residents have the potential to be affected by the deficient practice of not resolving grievances in a timely manner. 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. 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. Nurse Educator or License Nurse will make rounds 2 times daily for 4 weeks; then daily for 4 weeks beginning	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25CG	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) COMPLETE DATE
M 500	Continued From page 6 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 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. Unresolved Grievances: 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	M 500	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. 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 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
	25CG	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) COMPLETE DATE
M 500	Continued From page 7	M 500		

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 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25CG	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) COMPLETE DATE
M 500	Continued From page 8 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 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	M 500		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25CG	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) COMPLETE DATE
M 500	Continued From page 9	M 500		

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 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).

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25CG	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) COMPLETE DATE
M 500	Continued From page 10 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 #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	M 500		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25CG	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) COMPLETE DATE
M 500	Continued From page 11	M 500		

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 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25CG	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) COMPLETE DATE
M 500	Continued From page 12 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 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	M 500		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25CG	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) COMPLETE DATE
M 500	Continued From page 13 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.	M 500		
M 640	45.21.8 Accidents Accidents. The facility shall ensure that the residents ' environment remains as free of accident hazards as possible, and adequate supervision shall be provided to prevent accidents. If an unexplained accident occurs, this injury must be investigated and reported to appropriate state agencies. This Statute is not met as evidenced by: Level III 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:	M 640	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	2/28/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25CG	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) COMPLETE DATE
M 640	Continued From page 14 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 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	M 640	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) 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	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25CG	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) COMPLETE DATE
M 640	Continued From page 15 (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 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	M 640	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
	25CG	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) COMPLETE DATE
M 640	Continued From page 16	M 640		

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 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25CG	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) COMPLETE DATE
M 640	Continued From page 17 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.".	M 640		