MSDH - Health Facilities Licensure and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15PC	A. BUILDING: _____ B. WING _____	C 06/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINE CREST GUEST HOME INC	133 PINE STREET HAZLEHURST, MS 39083

(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 a Complaint Investigation (CI), MS #29217 and CI MS #29218, at the facility from 6/11/25 through 06/16/25. CI MS #29217 was investigated related to physical environment and offensive odors. There were no citations related to this CI. During the survey, the SA determined the facility was not in compliance with Minimum Standards for Institutions for the Aged or Infirm, state licensure requirements and cited M500 and M640 related to CI 29218. On 06/05/25 Resident #1 was transported to an appointment by the Administrator in a wheelchair at 1:06 PM without assistance from a nurse or Certified Nursing Assistant (CNA). At 1:49 PM on 06/05/25 the Administrator called Licensed Practical Nurse (LPN)#1 to inform her that Resident#1 had slipped from the wheelchair, but he stated she was not injured and was on the way back to the facility with the resident. Resident #1 was transported back to the facility while lying on the floor of the facility van for approximately 42 miles and arrived back at the facility at 2:40 PM. The facility's failure to ensure Resident #1 was properly secured and transported safely, under trained supervision, resulted in her fall from a wheelchair in the facility van and lack of assessment by licensed personnel immediately following the fall placed Resident #1 in a situation that was likely to cause serious injury, harm, impairment, or death. During the investigation of the complaint, the SA identified Immediate Jeopardy (IJ) and Substandard Quality of Care (SQC) which began on 06/05/25 and Rule 45.17.2 -Resident Rights (M500) and Rule 45.21.8- Accidents (M640)	M 000		

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M 000	Continued From page 1 existed at Scope and Severity of "J". The SA notified the facility's Administrator of the IJ and SQC on 06/13/25 at 4:20 PM. The facility submitted an acceptable Removal Plan in which they alleged all corrective actions to remove the IJ were completed on 6/14/25 and the IJ removed on 06/15/25. The SA validated the Removal Plan on 06/16/25 and determined that corrective actions to remove the immediacy were completed on 6/14/25 and the IJ was removed on 06/15/2025, prior to exit on 6/16/25. Therefore, the scope and severity of Rule 45.17.2- Resident Rights (M500) - Scope and Severity of "J" and Rule 45.21.8 -Accidents (M640)- Scope and Severity of "Level IV" was lowered to a Scope and Severity of "Level II" while the facility develops a plan of correction to monitor the effectiveness of systemic changes to ensure the facility sustains compliance with regulatory requirements.	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 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;	M 500		7/14/25

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M 500	Continued From page 2 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 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	M 500		

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M 500	Continued From page 3 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 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	M 500		

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M 500	Continued From page 4 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 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	M 500		

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M 500	Continued From page 5 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 IV Based on observation, interview, and record review, the facility failed to protect the resident's right to be free from neglect when the facility failed to obtain immediate medical assistance for Resident #1 who sustained a fall from a wheelchair in the facility van. Resident #1 was transported back to the facility while lying on the floor of the facility van and was not assessed by licensed personal for approximately thirty (30) minutes during transport for one (1) of four (4) sampled residents (Resident #1). On 06/05/25 Resident #1 was transported to an appointment by the Administrator in a wheelchair at 1:06 PM without assistance from a nurse or Certified Nursing Assistant (CNA). At 1:49 PM on 06/05/25 the Administrator called Licensed Practical Nurse (LPN)#1 to inform her that Resident#1 had slipped from the wheelchair, but he stated she was not injured and was on the way back to the facility with the resident. Resident #1 was transported back to the facility while lying on the floor of the facility van for approximately 42 miles and arrived back at the facility at 2:40 PM. The facility's failure to ensure Resident #1 was properly secured and transported safely, under trained supervision, resulted in her fall from a wheelchair in the facility van. Resident #1 was transported back to the facility while lying on the	M 500		

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M 500	Continued From page 6 floor of the facility van for approximately thirty minutes. This failure and a lack of immediate assessment by licensed personnel placed the resident in a situation that was likely to cause serious injury, serious harm, serious impairment, or death. The situation was determined to be Immediate Jeopardy (IJ) and Substandard Quality of Care (SQC), which began on 6/05/25, when Resident #1 sustained a fall from a wheelchair in the facility van and was not assessed by licensed personal for approximately thirty (30) minutes during transport. The State Agency (SA) notified the Administrator of the IJ on 6/13/25 at 04:20 PM and provided an IJ Template. The SA validated the Removal Plan on 06/16/25, and determined that the IJ was removed on 06/15/25, prior to SA exit. Therefore, the scope and severity for CFR §483.12 Freedom from Abuse, Neglect, and Exploitation - F600 was lowered from a "J" to a "D" while the facility develops a plan of correction to monitor the effectiveness of the systemic changes to ensure the facility sustains compliance with regulatory requirements. Findings include: A review of the facility's policy, "Transportation Assistant Document," dated Copyright 2024, revealed, "Position Purpose; Provides transport assistive services to assigned residents in accordance with care plans, facility policies and procedures and at the direction of supervisor(s); Required Qualifications... Certified Nursing Assistant in good standing with the state... Current CPR/BLS (Cardiopulmonary Resuscitation/Basic Life Support) certifications."	M 500		

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M 500	Continued From page 7 A review of the facility's policy, "Transporting a Resident (Facility Van)," dated Copyright 2025, revealed, " ...It is the policy of this facility to provide residents safe, non-emergency transportation to doctor's appointments ... 3.Facility will ensure that residents who require an escort to appointments due to cognitive or physical limitations have arrangements made ahead of time ...6.Each resident will be secured in a seat with a seatbelt or in their wheelchair secured with wheelchair tie downs ..." Record review of the incident report dated 6/5/2025 revealed "Resident arrived at facility in facility van accompanied by facility employee. Resident positioned on buttocks, resting on bilateral footrests. Resident WC (wheelchair) foot pedals resting on van floor. WC secured with four floor harnesses. Tilted forward slightly. Lap seat belt buckled but not tightened across resident abdominal area. Pressure cushion tilted forward slightly and down towards floors at front edge of WC seat, resting against mid-thoracic region of back. Resident's left foot extended straight beneath back bench seat, sock intact. Right lower extremity extended forward slightly with knee flexed and right foot resting in front of pelvic region. Sock is intact to right foot. Does not recall how she came to be seated on bilateral WC footrests on van floor." On 06/11/2025 at 3:49 PM, during an interview with the Resident Representative (RR) for Resident #1, she explained that the Director of Nursing Services (DNS) informed them that Resident #1 had fallen out of her wheelchair in the van during transport and was returned to the facility unsecured on the floor. She stated that the Administrator should have contacted emergency	M 500		

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M 500	Continued From page 8	M 500		

services and not transported the resident alone. She confirmed Resident #1 was admitted to a medical center on 06/06/2025 due to Congestive Heart Failure, Urinary Tract Infection, and Septicemia.

On 06/11/2025 at 4:15 PM, during an interview with the Administrator, he explained he transported Resident #1 alone to an appointment approximately thirty-five (35) miles away. He stated the resident began scooting forward, fell to the floor of the van, and did not verbally respond after the fall. He confirmed he did not seek emergency assistance and drove back to the facility with the resident lying on the floor between the back of a van seat and the wheelchair.

On 06/12/2025 at 11:15 AM, during an interview with the Director of Nursing Services (DNS), she explained she was unaware that the Administrator transported Resident #1 alone and did not call emergency services after the fall. She described the resident's position as lodged between the wheelchair and van seat, with her legs extended and the seatbelt loose. Emergency services were contacted at 2:43 PM and arrived at 2:50 PM. The DNS confirmed the Administrator had not contacted them during the return transport.

On 06/12/2025 at 3:00 PM, during an observation, the Administrator demonstrated the resident's position on the van floor, confirming the resident was lodged between the wheelchair and a van seat with her legs extended and unrestrained.

A record review of Resident #1's Admission Record revealed an admission date of 02/20/2025 with diagnoses including Major Depressive Disorder, Dementia, Lung Cancer,

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M 500	Continued From page 9 Panic Disorder, and Difficulty Walking. A record review of Resident #1's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 05/27/2025 revealed a Brief Interview for Mental Status (BIMS) score of six (6), indicating severely impaired cognition. The MDS identified Resident #1 as non-ambulatory and dependent on a wheelchair for mobility. The facility implemented the following plan to remove the Immediate Jeopardy: Incident on 06/05/25 Resident #1 was transported to an appointment by the Administrator in a wheelchair at 1:06pm with no assistance from nurse or certified nursing assistant(CNA). At 1:49 pm on 06/05/25 the Administrator called Licensed Practical Nurse (LPN)#1 to inform her that Resident#1 had slipped from wheelchair, but he stated she was not injured and was on the way back to the facility with the resident. Director of Nursing(DON) was notified by LPN#1 that the Administrator was on the way back to the facility with the resident in the transportation van. At 2:40 pm on 06/05/25, the Administrator arrived and DON, Assistant Director of Nursing(ADON), Quality Assurance(Q/A) nurse and LPN#1 went out to the van to assess the resident. Resident #1 was on the floor of the van with the wheelchair at her back. DON and ADON assessed Resident#1 without moving resident with no apparent injuries noted. Resident#1 rated pain 0 using a 0-10 pain scale. Ambulance service was notified at 2:43pm by the Charge Nurse. The van doors were shut and air turned up with DON and ADON at her side to ensure she was safe until the ambulance arrived.	M 500		

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M 500	Continued From page 10 At approximately 2:50pm two ambulances arrived along with the fire department. Using three(3) person total assistance, the wheelchair was unlocked from its 4-point harness. Leg rests were moved outward and folded from the sides of the wheelchair. Wheelchair was gently moved backwards from the Resident#1. Resident#1 verbally stated she was okay. Emergency Medical Services(EMS) personnel transferred Resident#1 onto a sheet from the floor of the van with 4-person total manual lift. Resident#1 was brought to the local hospital and was evaluated by the emergency department provider. Resident#1 arrived back at the facility at 6:46 pm by ambulance with no further orders at the time. Upon resident's arrival it was noted x-rays were not obtained at the emergency department. Medical Doctor(MD) was notified and x-rays were ordered for 23 views. Portable x-ray performed the x-rays. Report was sent over stat and no injuries were noted on x rays. On 6/06/25 Nursing and transportation staff were educated immediately requirements of having a CNA or nurse who is Cardiac Pulmonary Resuscitation(CPR) certified to provide non-emergency transport of residents and having two staff members who meet the requirements to transport residents. Education is ongoing with all nursing and transportation staff and will not work till completed. On 06/12/25 QA nurse met with the therapy director to put in place for all residents to be screened for appropriate mobility devices for transport. Emergency Q/A and safety meeting was held on 06/06/25 at 9:30am and 06/13/25 at 6 pm and	M 500		

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M 500	Continued From page 11	M 500		

included the following persons:
*Nursing Home Administrator
*Medical Director
*Director of Nursing (DON)
* Assistant DON
*QA/Infection Preventionist
*Social Services
*MDS Nurse
*Medical Records Nurse
*Staff Development Nurse
*Treatment Nurse
*Charge Nurse Topics addressed:
*IJ Finding- F689
*Root cause analysis
*Corrective action plan
*Staff Education
*Systemic Changes
*Monitoring Plan

The "Abuse, Neglect, Exploitation, and Misappropriation Prevention Program" policy was reviewed. No revisions were required.

On 06/06/25 1 on 1 in-services on Abuse, Neglect, and Misappropriation, as well as, Requirements and Safety of Non-emergent Transportation were done with the Administrator by DON and ADON.

A directive in-service was started on Saturday 06/14/25 by the Vice President of Clinical Operations on Resident safety during transport and Fall Response for all Nursing Staff.

On 06/14/25 Staff who are allowed to transport residents were verified by checking to make sure they are on the company's insurance policy and CPR certified by the DON.

The Q/A Nurse reviewed/monitored Resident#1's

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M 500	Continued From page 12 most recent MOS and most recent therapy screen for appropriate transportation on 06/06/25. CONCLUSION: Based on the immediate corrective actions taken, staff education completed, systemic practice changes, and monitoring processes established, Pinecrest Guest Home alleges that the Immediate Jeopardy was abated as of June 14, 2025. Validation: The SA validated on 06/16/25 through interview and record review that all actions to remove the immediacy were completed on 6/14/25 and the IJ was removed on 6/15/25 prior to the SA exit.	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 IV Based on observation, interview, and record review, the facility failed to protect a resident from accidents hazards when the facility failed to obtain immediate medical assistance when a resident sustained a fall from a wheelchair in the facility van and was not assessed by licensed personnel for approximately 42 miles while being	M 640		7/14/25

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M 640	Continued From page 13	M 640		

transported back to the facility while lying on the floor for one (1) of four (4) sampled residents. (Resident #1).

The facility's failure to ensure Resident #1 was properly secured and transported safely, under trained supervision, resulted in her fall from a wheelchair in the facility van. Resident #1 was transported back to the facility while lying on the floor of the facility van for approximately 42 miles and arrived back at the facility at 2:40 PM. This failure and a lack of immediate assessment by licensed personnel placed the resident in a situation that was likely to cause serious injury, serious harm, serious impairment, or death.

The situation was determined to be an Immediate Jeopardy (IJ) and Substandard Quality of Care (SQC), which began on 6/05/25, when Resident #1 sustained a fall from a wheelchair in the facility van and was not assessed by licensed staff for approximately thirty (30) minutes during transport. The State Agency (SA) notified the Administrator of the IJ on 6/13/25 at 04:20 PM and provided an IJ Template.

The SA validated the Removal Plan on 06/16/25, and determined that the IJ was removed on 06/15/25, prior to SA exit. Therefore, the scope and severity for CFR 483.25(d)(1)(2) Accidents/Hazards - F689 was lowered from a "J" to a "D" while the facility develops a plan of correction to monitor the effectiveness of the systemic changes to ensure the facility sustains compliance with regulatory requirements.

Findings include:

A review of the facility's policy, "Transportation Assistant Document," dated Copyright 2024,

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	15PC	A. BUILDING: _____ B. WING _____	C 06/16/2025

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PINE CREST GUEST HOME INC	133 PINE STREET HAZLEHURST, MS 39083

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revealed, "Position Purpose; Provides transport assistive services to assigned residents in accordance with care plans, facility policies and procedures and at the direction of supervisor(s); Required Qualifications... Certified Nursing Assistant in good standing with the state... Current CPR/BLS (Cardiopulmonary Resuscitation/Basic Life Support) certifications."

A review of the facility's policy, "Transporting a Resident (Facility Van)," dated Copyright 2025, revealed, " ...It is the policy of this facility to provide residents safe, non-emergency transportation to doctor's appointments ... 3.Facility will ensure that residents who require an escort to appointments due to cognitive or physical limitations have arrangements made ahead of time ...6. Each resident will be secured in a seat with a seatbelt or in their wheelchair secured with wheelchair tie downs ..."

Record review of the incident report dated 6/5/2025 revealed "Resident arrived at facility in facility van accompanied by facility employee. Resident positioned on buttocks, resting on bilateral footrests. Resident WC (wheelchair) foot pedals resting on van floor. WC secured with four floor harnesses. Tilted forward slightly. Lap seat belt buckled but not tightened across resident abdominal area. Pressure cushion tilted forward slightly and down towards floors at front edge of WC seat, resting against mid-thoracic region of back. Resident's left foot extended straight beneath back bench seat, sock intact. Right lower extremity extended forward slightly with knee flexed and right foot resting in front of pelvic region. Sock is intact to right foot. Does not recall how she came to be seated on bilateral WC footrests on van floor."
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M 640	Continued From page 15 During an interview on 06/11/2025 at 3:49 PM, the Resident Representative (RR) for Resident #1, she explained that the Director of Nursing Services (DNS) informed them that Resident #1 had fallen out of her wheelchair in the van during transport and was returned to the facility unsecured on the floor. They stated that the Administrator should have contacted emergency services and not transported the resident alone. They confirmed Resident #1 was admitted to a medical center on 06/06/2025 due to Congestive Heart Failure, Urinary Tract Infection, and Septicemia. During an interview on 06/11/2025 at 4:15 PM, with the Administrator, he explained he transported Resident #1 alone to an appointment approximately thirty-five (35) miles away. He stated the resident began scooting forward, fell to the floor of the van, and did not verbally respond after the fall. He confirmed he did not seek emergency assistance and drove back to the facility with the resident lying on the floor between the back of a van seat and the wheelchair. During an interview on 06/12/2025 at 11:15 AM, with the DNS, she explained she was unaware that the Administrator transported Resident #1 alone and did not call emergency services after the fall. They described the resident's position as lodged between the wheelchair and van seat, with her legs extended and the seatbelt loose. Emergency services were contacted at 2:43 PM and arrived at 2:50 PM. The DNS confirmed the Administrator had not contacted them during the return transport. During an observation on 06/12/2025 at 3:00 PM, the Administrator demonstrated the resident's position on the van floor, confirming the resident	M 640		

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was lodged between the wheelchair and a van seat with her legs extended and unrestrained.

A record review of Resident #1's Admission Record revealed an admission date of 02/20/2025 with diagnoses including Major Depressive Disorder, Dementia, Lung Cancer, Panic Disorder, and Difficulty Walking.

A record review of Resident #1's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 05/27/2025 revealed a Brief Interview for Mental Status (BIMS) score of six (6), indicating severely impaired cognition. The MDS identified Resident #1 as non-ambulatory and dependent on a wheelchair for mobility.

The facility implemented the following plan to remove the Immediate Jeopardy:

Incident on 06/05/25 Resident #1 was transported to an appointment by the Administrator in a wheelchair at 1:06pm with no assistance from nurse or certified nursing assistant(CNA). At 1:49pm on 06/05/25 the Administrator called LPN#1 to inform her that Resident#1 had slipped from wheelchair, but he stated she was not injured and was on the way back to the facility with the resident.

Director of Nursing(DON) was notified by LPN#1 that the Administrator was on the way back to the facility with the resident in the transportation van. At 2:40pm on 06/05/25, the Administrator arrived and DON, Assistant Director of Nursing(ADON), Quality Assurance(Q/A) nurse and LPN#1 went out to the van to assess the resident. Resident #1 was on the floor of the van with the wheelchair at her back. DON and ADON assessed Resident#1 without moving resident with no apparent injuries

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M 640	Continued From page 17 noted. Resident#1 rated pain 0 using a 0-10 pain scale. Ambulance service was notified at 2:43pm by the Charge Nurse. The van doors were shut and air turned up with DON and ADON at her side to ensure she was safe until the ambulance arrived. At approximately 2:50pm two ambulances arrived along with the fire department. Using three(3) person total assistance, the wheelchair was unlocked from its 4-point harness. Leg rests were moved outward and folded from the sides of the wheelchair. Wheelchair was gently moved backwards from the Resident#1. Resident#1 verbally stated she was okay. Emergency Medical Services(EMS) personnel transferred Resident#1 onto a sheet from the floor of the van with 4-person total manual lift. Resident#1 was brought to the local hospital and was evaluated by the emergency department provider. Resident#1 arrived back at the facility at 6:46pm by ambulance with no further orders at the time. Upon resident's arrival it was noted x-rays were not obtained at the emergency department. Medical Doctor(MD) was notified and x-rays were ordered for 23 views. Portable x-ray performed the x-rays. Report was sent over stat and no injuries were noted on x rays. On 6/06/25 Nursing and transportation staff were educated immediately requirements of having a CNA or nurse who is Cardiac Pulmonary Resuscitation(CPR) certified to provide non-emergency transport of residents and having two staff members who meet the requirements to transport residents. Education is ongoing with all nursing and transportation staff and will not work till completed.	M 640		

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M 640	Continued From page 18 On 06/12/25 QA nurse met with the therapy director to put in place for all residents to be screened for appropriate mobility devices for transport. Emergency Q/A and safety meeting was held on 06/06/25 at 9:30am and 06/13/25 at 6pm and included the following persons: *Nursing Home Administrator *Medical Director *Director of Nursing (DON) * Assistant DON *QA/Infection Preventionist *Social Services *MOS Nurse *Medical Records Nurse *Staff Development Nurse *Treatment Nurse *Charge Nurse Topics addressed: *IJ Finding- F689 *Root cause analysis *Corrective action plan *Staff Education *Systemic Changes *Monitoring Plan The "Abuse, Neglect, Exploitation, and Misappropriation Prevention Program" policy was reviewed. No revisions were required. On 06/06/25 1 on 1 in-services on Abuse, Neglect, and Misappropriation, as well as, Requirements and Safety of Non-emergent Transportation were done with the Administrator by DON and ADON. A directive in-service was started on Saturday 06/14/25 by the Vice President of Clinical Operations on Resident safety during transport	M 640		

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M 640	Continued From page 19 and Fall Response for all Nursing Staff. On 06/14/25 Staff who are allowed to transport residents were verified by checking to make sure they are on the company's insurance policy and CPR certified by the DON. The Q/A Nurse reviewed/monitored Resident#1's most recent MOS and most recent therapy screen for appropriate transportation on 06/06/25. CONCLUSION: Based on the immediate corrective actions taken, staff education completed, systemic practice changes, and monitoring processes established, Pinecrest Guest Home alleges that the Immediate Jeopardy was abated as of June 14, 2025. Validation: The SA validated on 06/16/25 through interview and record review that all actions to remove the immediacy were completed on 06/14/25 and the IJ was removed on 06/15/25 prior to the SA exit.	M 640		