Mississippi State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **12/09/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINE FOREST HEALTH AND REHABILITATION	**1116 FOREST AVENUE , JACKSON, Mississippi, 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
M0000	Initial Comments The State Agency (SA) conducted a Complaint Investigation (CI), MS #2662480, at the facility from 12/08/25 through 12/09/25. MS #2662480 was a facility reported incident related to an accident. During the survey, the SA determined the facility was not in compliance with the Minimum Standards for Institutions for the Aged or Infirm, state licensure requirement and cited M640.	M0000		
M0640	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 LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on record review, interview, and facility policy review, the facility failed to ensure the resident environment was free of accident hazards by failing to follow secure a wheelchair during van loading, which resulted in an avoidable accident that caused a scapular fracture and multiple rib fractures for one (1) of three (3) sampled residents (Resident #1). Findings Included: Review of the facility's policy "Facility Vehicle Standard" revised October 2025, revealed "…Van Operation Standard The facility shall provide safe transportation for residents. Procedures…2. Loading and unloading residents…E. Follow manufacturer's instructions for operating the lift. 1. Load wheelchair onto lift…b. Lock brakes…C. In the event of a health emergency, the following steps will be followed: 1. The driver will call 911 and provide any necessary emergency first aid until trained medical personnel arrive and take over…" Record review of the "Admission Record" revealed the	M0640		

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

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M0640	Continued from page 1 facility admitted Resident #1 on 5/16/25 with diagnoses including Hemiplegia, unspecified affecting right dominant side. Record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 8/30/25 revealed Resident #1 had a Brief Interview for Mental Status (BIMS) score of 13, which indicated she was cognitively intact. Further review revealed she could not walk and required a wheelchair for mobility/locomotion. Record review of the facility' investigation with a "Subject" of "Unwitnessed Fall", dated 11/8/25, revealed that on 11/03/25 at approximately 12:53 PM, Certified Nurse Aide (CNA) #3 contacted Licensed Practical Nurse (LPN) #1 via cellphone to report that Resident #1 experienced a fall. The CNA reported that the incident occurred while loading the resident onto the liftgate of the facility van. He reported that the left wheelchair wheel was locked, but the right wheel was not, causing the wheelchair to roll backward, resulting in the resident falling back onto her back. She was assisted back into the wheelchair. LPN #1 instructed the CNA to return the resident to the facility for assessment. The resident arrived back at the facility at approximately 1:03 PM and was assessed. There were no visible injuries, and the resident denied pain at that time. Tylenol was administered as a precaution, and the Responsible Party (RP) was notified. Later that evening, the resident began complaining of back pain and was transported to a local hospital at approximately 9:31 PM. During the investigation by the Administrator and the Director of Nursing (DON), CNA #3 reiterated that he had failed to lock both wheelchair wheels before lifting the resident onto the van's liftgate. He confirmed that the fall occurred while on the ground, not during lift movement. Following a complete investigation, it was determined that CNA #3 failed to properly secure and lock the resident's wheelchair, resulting in an unsafe fall while under his supervision. CNA #3 was terminated. Record review of a handwritten statement signed by CNA #3, undated but attached to the facility's investigation, revealed, "…I locked the right wheel and did not the left. I let the platform up and she rolled back and fell back. I pick her up and put her back in her chair…I talked to the nurse…She instructed me to bring her to the facility…" Record review of the acute hospital's Emergency Department (ED) records, dated 11/03/25, revealed Resident #1 had a "Chief Complaint" of "Fall, Back	M0640		

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M0640	Continued from page 2 Pain" and that she "States her whole back hurts. Hit her head but did not lose consciousness…" Review of the computed tomography (CT) scan revealed "Findings" of "…Partially imaged acute right scapular fracture. Acute mildly displaced posterior right 3rd through 8th rib fractures…" On 12/08/25 at 2:54 PM, during an interview with Licensed Practical Nurse (LPN) #1, she explained that while on duty on 11/03/25, she received a telephone call on her personal cellular device from CNA #3. She reported that CNA #3 informed her that Resident #1 had experienced a fall during transport and asked what actions should be taken, including whether the resident should be sent to the emergency department. LPN #1 reported that she initially misunderstood the information provided and believed Resident #1 and CNA #3 were located in the facility's parking lot. She stated she notified the Director of Nursing (DON) and proceeded toward the parking lot to assess the situation, at which time she realized the resident and CNA were not at the facility. She confirmed that Resident #1 later returned to the facility, and shortly thereafter, CNA #3 transported the resident to the front nurses' station and then to the resident's room. LPN #1 confirmed that CNA #3 informed her he had failed to lock both wheelchair wheels. On 12/08/25 at 3:05 PM, during an interview with Licensed Practical Nurse (LPN) #2, she reported that at approximately 1:05 PM on 11/03/25, CNA #3 transported Resident #1 to her room following dialysis. She explained that CNA #3 told her the resident's dialysis treatment had been completed and that he was preparing to use the lift to return Resident #1 to the van while she was seated in her wheelchair. She reported that CNA #3 acknowledged he failed to lock one of the wheelchair wheels, which caused the wheelchair to roll and tip backward. LPN #2 stated she specifically asked whether the lift was elevated at the time of the incident, and CNA #3 denied that the lift was off the ground. She further reported that CNA #3 told her the resident did not fall out of the wheelchair and did not hit her head, stating the wheelchair handles stopped the backward movement. LPN #2 confirmed that LPN #3 completed a body audit of the resident. She added that immediately after returning from dialysis, Resident #1 went to the shower room and did not voice any complaints during her shift, which ended at 3:00 PM. On 12/08/25 at 3:40 PM, during a telephone interview with Resident #1, she explained that following her dialysis treatment on 11/03/25, CNA #3 failed to lock both wheels of her wheelchair. She reported that while	M0640		

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M0640	Continued from page 3 the facility van lift platform was being elevated, with her seated in the wheelchair on the platform, the wheelchair rolled backward off the platform, causing her to fall backward while still in the wheelchair and land on her right side on the concrete driveway. She stated that CNA #3 did not call emergency services or seek assistance from qualified personnel to evaluate her. Instead, she reported that CNA #3 repositioned the wheelchair upright with her still seated, loaded her onto the van, and transported her back to the facility. She stated that she informed facility staff upon return that she was in pain and had struck her head during the fall. She reported that her pain was not relieved by as-needed over-the-counter analgesics and that she remained in pain until approximately 9:35 PM on 11/03/25, when she was transported to a local acute care hospital. She confirmed that she was diagnosed with six fractures to her right ribs and a fracture of the right scapula (shoulder) and stated that she remained hospitalized at the time of the interview. On 12/09/25 at 2:54 PM, during a telephone interview with CNA #2, she explained that she was assigned to Resident #1 during the 3:00 PM through 11:00 PM (3–11) shift on 11/03/25. She reported that she was informed the resident had experienced a fall while attending her routine renal dialysis appointment during the 7:00 AM through 3:00 PM (7–3) shift. She reported that during her shift, the resident complained of pain to her right side and shoulder. She further reported observing that the resident's respirations appeared irregular and described them as "weird." CNA #2 confirmed that she reported the resident's complaints of pain and her observation of irregular respirations to the nurse. On 12/09/25 at 3:00 PM, during a telephone interview with LPN #4, she explained that upon Resident #1's return from dialysis treatment on 11/03/25, the van driver informed her that the resident had experienced a fall. She reported that she assessed Resident #1 for pain and administered an over-the-counter analgesic. She further reported that she reassessed the resident for effectiveness of the analgesic and that the resident continued to report pain. LPN #4 stated she notified Nurse Practitioner (NP) #1 of the resident's pain unrelieved by the available pain medication, and NP #1 ordered diagnostic testing. She reported that, based on the resident's and family's preference, NP #1 ordered the resident to be transported to a local acute care hospital for further evaluation and treatment as needed. On 12/09/25 at 3:20 PM, during an interview with the Maintenance Supervisor, he explained that when loading	M0640		

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M0640	Continued from page 4 or unloading residents into or out of the facility van, the lift platform should not be raised or lowered unless the resident's wheelchair wheels are locked. He confirmed that failure to ensure the wheels are locked increases the risk that the wheelchair could move and potentially fall from the platform. On 12/09/25 at 3:30 PM, during an interview with the Administrator, she explained that the conclusion of her investigation was that CNA #3 failed to lock the wheels of Resident #1's wheelchair during the loading process at the renal dialysis center prior to transporting the resident back to the facility. She confirmed that CNA #3 did not follow facility policy or procedure for loading residents into the facility van. She further confirmed that these actions directly resulted in Resident #1 falling from the facility van lift platform onto the concrete driveway at the dialysis center on 11/03/25, landing on her right side and sustaining a scapular and rib fractures.	M0640		