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Form Approved OMB
No. 0938-0391

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	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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. 42807 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 admitted 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. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 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.

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42807 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 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 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 admitted [DATE]) and the resident had diagnoses including Paraplegia. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 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 admitted [DATE]) 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 . (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 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 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. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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.

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 42807 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 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 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. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	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 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.