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	02/26/2025

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 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44179 Based on observation, interview, record review, and facility policy review, the facility failed to ensure a resident's right to be free from physical abuse for one (1) of five (5) sampled residents when Certified Nurse Aide (CNA) #1 used physical force with Resident #1, who was cognitively impaired and had right hemiparesis, was observed with purplish-red discoloration under the right eye, abrasions on the nose, and a hematoma on the forehead following an incident in which CNA #1 admitted to pressing down on Resident #1's left arm (the only functional arm) and using physical force on his face to prevent the resident from hitting her. Findings Included: A review of the facility's policy, Freedom of Abuse, Neglect and Exploitation Standard, revised 11/2019, revealed, .The purpose of this written Freedom of Abuse .Standard is to outline the preventive and action steps taken to reduce the potential for abuse, mistreatment and neglect of residents .Standard Statement This facility shall not condone any acts of resident mistreatment, neglect, verbal, sexual, physical and/or mental abuse .by any facility staff member .Definitions .Abuse means the willful infliction of injury .with resulting physical harm, pain or mental anguish .Willful means the individual means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm .Physical Abuse includes, but is not limited to, hitting, slapping, punching, biting, and kicking. It also includes controlling behavior through corporal punishment . A record review of the clinical profile revealed the facility admitted Resident #1 on 6/28/23 and he had diagnoses including Hemiplegia and Hemiparesis following Cerebral Infraction Affecting Right Dominant Side. A record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 11/28/24 revealed Resident #1 had a Brief Interview for Mental Status (BIMS) score of 7, which indicated his cognition was severely impaired. A review of Section B revealed his speech was unclear, and he is usually understood regarding his ability to express ideas and wants, and he usually understands verbal content from others. A review of Section E revealed he did not exhibit physical or verbal behaviors toward others, and he had not exhibited any behaviors related to rejection of care. A review of Section GG revealed he had impairment on one side for the upper and lower extremity and he was dependent on staff for toileting hygiene. A review of Section H revealed he is always incontinent of urine. A review of Section I revealed a diagnosis of Hemiplegia or Hemiparesis. (continued on next page)

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

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	02/26/2025

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 0600 Level of Harm - Actual harm Residents Affected - Few	A record review of the facility's investigation, dated 2/14/25, revealed that at approximately 1:30 AM on 1/9/2025, Licensed Practical Nurse (LPN) #1 reported that Resident #1 made an allegation of abuse related to CNA #1. The resident was immediately evaluated and interviewed by LPN #1 and sent out to the hospital for further evaluation. CNA #1 was questioned and sent home pending the outcome of the investigation. The staff wrote statements. The resident returned to the facility at 4:30 AM and was evaluated. He had bruising noted to right eye and hematoma noted to right side of head. Resident #1 stated that he hit the CNA first and he bit her after she hit him. The DON conducted a phone interview with Resident #1 who stated that she entered the room to help the resident prepare for bed and he needed to be changed. When she explained that he needed to be changed, he became aggressive and started swatting at her. She again explained to the resident the importance of getting cleaned up. She asked the resident to roll over so she could finish providing care and that's when the resident hit the CNA the first time. CNA #1 stated she put her hand up to prevent him from hitting her again. She admitted she did apply pressure to his arm. Resident #1 continued to be difficult. She stated at this time she called for help from CNA #2 who was in the room assisting the resident's roommate. As she was calling for help, the resident bit her finger. CNA #1 said she placed her right hand up the resident's nose to see if he would let her finger go from his mouth. CNA #1 said the resident bit harder and then finally let go and she left the room. Resident #1 was interviewed and stated that he hit her first and bit her after she hit me. When asked what caused the event to happen, resident pointed to his private area. He then stated he did not want to be changed. Internal investigator revealed the allegation of abuse cannot be substantiated because Resident #1 was the aggressor, and staff was attempting to prevent the resident from hitting her again. A record review of the Employee/Witness Statement Report, dated 2/9/25, revealed Resident #2, who is Resident #1's roommate stated, The other CNA was giving me care. I heard some scuffling, and I heard a loud pop. A record review of a handwritten statement, dated 2/9/25, and signed by CNA #2 revealed she was assisting with Resident #1's roommate into bed and heard Resident #1 resisting care and while going to assist with care, noticed resident was holding tight to the CNA. Once separated, CNA #1 exited the room. (continued on next page)

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	02/26/2025

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 0600 Level of Harm - Actual harm Residents Affected - Few	A record review of a handwritten statement, dated 2/9/25, and signed by LPN #1, revealed CNA #1 approached the nurse's station to report that Resident #1 became combative during perineal care. CNA #1 presented her finger to LPN #1 and stated that Resident #1 bit down on her finger and wouldn't let go. Finger noted red and swollen with purple spotted discoloration at the base. LPN #1 offered to help due to her stating the resident was giving us a hard time. CNA#1 assured LPN #1 that everything was under control. After approximately 20 minutes, CNA's #3 and #4 approached LPN #1 and reported that Resident #1 stated that the girls that just left hit him. The CNA's also reported that his roommate stated he heard a lot of commotion from the other side of the room, followed by a loud pop. The CNAs stated they noted swelling under [NAME] his right eye and a bloody nose, with a knot to right temple. LPN #1 immediately went to Resident #1's room and observed purplish-red discoloration under his right eye. Light red scratches along the perimeters of the discoloration beneath right eye. Scratches noted to bridge of Resident #1's nose on the right side. Dry blood noted at right inner nostril. Spotted drops of blood noted to sheet covering Resident #1's lap. [NAME] sized knot noted at right temple. LPN #1 notified the DON of the allegation and was advised to interview the resident more thoroughly. Resident pointed towards the doorway and LPN #1 asked resident if someone had hit him and he nodded his head up and down. Asked who and the resident stated the girl and pointed to his doorway. Resident stated he hit her and she hit him. Resident indicated he was hit in the nose. Resident shook his head No when asked if he was hit in the eye. Resident was noted to be wide-eyed and pressed for words at this time LPN #1 interviewed Resident #2 (Roommate for Resident #1) and he stated he heard a lot of commotion while CNA #2 was assisting him and then CNA #2 rushed over to intervene. The resident denied hearing a pop as stated earlier by CNA #3 and #4. Resident #2 shook his head no and shrugged his shoulders when asked if he felt anything malicious was going on between the CNAs and Resident #1. LPN #1 asked Resident #1 four (4) times if he was hit by a staff member, which he confirmed verbally and with gestures each time. LPN #1 asked CNA #2 what she knew concerning Resident #1 and she stated that Resident #1 began to resist care and became combative when she ran over to assist. She stated Resident #1 was noted biting down on CNA #1's finger. LPN #1 asked CNA #1 what she knew concerning the changes observed on Resident #1's face and bloody nose. CNA #1 stated that he (Resident #1) gripped her finger with his teeth and refused to let go. CNA #1 stated she grabbed the resident around the bridge of his nose in an attempt to make him open his mouth and that he only began to bite harder. LPN #1 told CNA #1 that Resident #1 stated he was hit in the nose and CNA #1 stated that she did not hit him the nose. A record review of the Employee/Witness Statement Report, dated 2/10/25, revealed CNA #1 went in to provide care and he was putting his hands down in front of him messing with himself. CNA #1 asked a few times for him to move his hands and let her finish changing him. She only had to put the brief between his legs and fasten it on the right side, but he continued to do it and starting hitting at CNA #1. CNA#1 put her arm up over his hand to keep him from hitting her and he continued to hit at her so she kept her arm up. CNA #1 stated she was pressing down to keep him from swinging out to hit her and his arm was over his chest at the time. The next thing she knew he was biting her finger on the right hand would not let go. She thought he was going to bite it completely off. She asked him to let go at this time and CNA #2 came to help her. She was telling the resident to her go and he bit down harder so she tried to put her left hand up and put her fingers over his nose and he bit down even harder. He finally let go and she grabbed her right hand with the left hand making a loud clapping noise and left the room. She notified the nurse. She stated that at no point during the encounter she thought it would be better for her to leave out because she was trying to provide care the resident needed and she denied hitting the resident. (continued on next page)

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	02/26/2025

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 0600 Level of Harm - Actual harm Residents Affected - Few	A record review of the acute hospital documentation, dated 2/9/25, revealed, .Reportedly concern for patient being struck by an individual at nursing home facility. Patient has abrasion over right side of face as well as dried blood to left nostril .Discharge Diagnosis: Assault . A record review of a Progress Note, dated 2/9/25 at 19:00 (7 PM) revealed, .noted swelling underneath right eye pink color . A record review of a Progress Note, dated 2/9/25 at 14:24 (2:24 PM) revealed, .Report called from (Proper Name of Acute Hospital) .Resident does have a hematoma on the forehead . A record review of a Progress Note, dated 2/10/24 at 16:20 (4:20 PM), for Resident #1, authored by LPN #2, revealed, .Small red bruise noted under right eye . A record review of a Progress Note, dated 2/10/24 at 8:51 AM, by LPN #1, revealed, late entry for 2/9/25 at 2045 PM (8:45 PM) - Resident observed sitting upright in wc (wheelchair) .Pink color remains noted under right eye . On 02/24/2025 at 5:22 PM, during an interview, Resident #2 stated that on 02/09/2025, while CNA #2 was assisting him, he heard a hitting sound but did not see anyone hitting Resident #1 when he looked over. He stated that CNA #1 entered the room to check if Resident #1 was wet, and he heard the sound of hitting again while CNA #2 remained with him on the other side of the room. Resident #2 recalled that CNA #2 asked CNA #1 if she needed help. He confirmed that he did not see CNA #1 hit Resident #1, nor did he see Resident #1 hit CNA #1. He stated that he only saw Resident #1's eye injury after both CNAs left the room. Resident #2 also stated that he had never observed Resident #1 refuse care or act aggressively toward staff. (continued on next page)

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	02/26/2025

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 0600 Level of Harm - Actual harm Residents Affected - Few	On 02/25/2025 at 9:53 AM, during a phone interview, CNA #1 stated that when she entered Resident #1's room on 2/9/25, she asked him if he was ready to lie down, and he nodded in agreement. At that time, CNA #2 entered the room to provide perineal care to Resident #2. CNA #1 stated that she began providing care by pulling down Resident #1's pants, removing his shoes, and placing a clean brief and draw sheet under him. She noted that Resident #1 placed his hands in his buttocks area, and when she asked him to move his hands, he complied. CNA #1 stated that Resident #1 then placed his hands in the front of his brief in the genital area. She repeatedly told him to stop, and while he would momentarily comply, he continued to place his hands in the genital area. She stated that she continued to provide perineal care and turned the resident on his side, but he repeatedly put his left arm in the way. CNA #1 explained that she applied her arm to his left forearm to prevent him from putting his hand in his genital area. She stated that Resident #1 continued to try to free his arm, and she applied more pressure to his forearm to complete the care. She noted that Resident #1 did not say anything during this interaction but continued to resist. While she was holding his forearm down, Resident #1 managed to get her finger into his mouth and began biting down on her finger. To get him to release her finger, CNA #1 stated that she placed her hand on his nose, hoping he would release her finger to breathe through his mouth, but instead, he bit down harder. At this point, CNA #2 approached and told Resident #1 to let go of CNA #1's finger. CNA #1 stated that her fingernails were longer than they were supposed to be, and she believed that she may have accidentally scratched Resident #1's nose during the incident. CNA #1 stated that she had been trained to leave the room and notify the nurse if a resident refuses care. She reflected that, in hindsight, she should have stopped providing perineal care and left the room. She explained that Resident #1 had previously cursed at staff, called them names, and hit at CNAs. CNA #1 stated that during the incident, she never yelled for help and that CNA #2 came over on her own to assist. She confirmed that Resident #1 did not break the skin on her finger but continued to bite down. She denied causing any injury to Resident #1's eye but acknowledged that his nose was scratched by her nails. She reiterated that she did not yell for help at any point during the incident. On 02/25/2025 at 12:17 PM, during an observation, Resident #1 was seen in the hallway. His right hand and arm were contracted, and he was using his left hand to maneuver his wheelchair. On 02/25/2025 at 12:47 PM, during a phone interview, Certified Nursing Assistant (CNA) #2 stated that on 2/9/25 at the time of the incident, she was assisting with Resident #2 and heard CNA #1 say stop. CNA #2 went over to the Resident #1's side of the room and observed Resident #1 holding onto CNA #1's shirt collar but did not see Resident #1 biting CNA #1's finger or any hitting between them. She stated that CNA #1 was holding both of Resident #1's arms in her hands. She did not know what had occurred to cause Resident #1 to grab CNA #1's shirt collar. She stated that she had been trained to leave the room if a resident refuses care. She observed a small amount of blood near Resident #1's nose but did not notice any injury to his eye. She stated that by his facial expression, she could tell that Resident #1 was agitated. She gave Resident #1 a paper towel for his bloody nose. She confirmed that CNA #1 never called for help or yelled during the incident. She stated that Resident #1 has a contracted right arm and is unable to use his right hand or arm. She explained that if she were in that situation, she would have left the room and returned later. She also stated that Resident #1 had never yelled, cursed, or tried to hit her or any other CNAs that she was aware of. (continued on next page)

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	02/26/2025

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 0600 Level of Harm - Actual harm Residents Affected - Few	On 02/25/2025 at 1:37 PM, during a phone interview, LPN #1 stated she went to Resident #1's room on 2/9/25 after CNA #3 and CNA #4 reported he had injuries to his face, and he had stated he had been hit. Resident #1 was sitting on the side of the bed appearing frightened, nervous, and wide-eyed. She stated that Resident #1 immediately tried to verbally communicate with her. She observed redness above his right eye, a small abrasion near his eye and on the bridge of his nose, and a dime-sized knot on the right side of his face. LPN #1 stated that when she spoke to Resident #1, he pointed to his nose area and stated that the girl hit me. She noted that he continued to point and make facial gestures throughout the interview. LPN #1 assessed Resident #1 and obtained an order from the Nurse Practitioner to send him to the emergency room for evaluation. She stated that Resident #1 is usually not upset, but during the incident, he appeared visibly upset by his facial expressions. She explained that she had seen Resident #1 twice during her shift and did not observe any injuries before the incident. She stated that Resident #1 had never exhibited behavioral issues such as cursing, yelling, or hitting staff, and no CNA had ever reported that he refused care or hit staff members. She noted that approximately 20 minutes before CNA #3 and CNA #4 approached her with the report of the resident's injuries, CNA #1 had told her that Resident #1 had bitten her finger hard, but that everything was under control. She stated that she did not go to the room immediately at that time because CNA #1 indicated that the situation was resolved. LPN #1 stated that CNA #1 never mentioned that Resident #1 had hit her or that she had hit him. She confirmed that CNA #1 did not yell out for help during the incident. LPN #1 also noted that Resident #1's room is located near the nurse's station. On 02/25/2025 at 2:08 PM, during an interview, Resident #1 used hand gestures as he attempted to verbally communicate. When asked if he hit CNA #1, he responded yes and nodded his head in agreement. He stated that CNA #1 hit him in his eye area and pointed to his face and nose with his left hand, while his right hand remained contracted at his side. Resident #1 stated that CNA #1 was rough with him and held him down tightly, pointing to his arm to indicate where he was held. He stated that she was hurting him, which caused him to hit her, but he denied biting her finger. Resident #1 stated that CNA #1 hit him with a closed fist in his face near his right eye. On 02/25/2025 at 2:22 PM, during an interview, the Director of Nursing (DON) stated that LPN #1 called her at the time of incident and reported that Resident #1 had bitten CNA #1's finger. She stated that prior to the incident, she had never been informed of Resident #1 displaying any behavioral issues, such as cursing, yelling, or hitting staff. She stated that when she saw Resident #1, he had red discoloration under his right eye. She was informed that CNA #1 was attempting to change Resident #1's brief at the time of the incident. She explained that if a resident refuses care, staff are expected to stop and leave the room, emphasizing that staff should never hold a resident down to provide care. She stated that the facility conducted an investigation but did not substantiate abuse. On 02/26/2025 at 8:48 AM, during a phone interview, CNA #3 stated that CNA #4 asked her to look at Resident #1's swollen face on 2/9/25 after the incident occurred. She stated that when they entered the room, the light was off. Resident #1 appeared jumpy, scared, and terrified and looked around nervously. Resident #1's face was swollen and bruised, with a bruise near his right eye and a small knot on the right side of his head. Resident #1 told her that he hit CNA #1 but did not bite her finger. She stated that she reported the injuries and allegation to the nurse and stated that Resident #1 had never hit or bitten her before. (continued on next page)

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	02/26/2025

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 0600 Level of Harm - Actual harm Residents Affected - Few	On 02/26/2025 at 8:54 AM, during a phone interview, CNA #4 stated she went into Resident #1's room after the incident occurred and noticed that Resident #1's nose was bleeding. She then went outside to get CNA #3, and they both returned to the room. She stated that when they knocked on the door and re-entered the room, they observed bruising near Resident #1's eye and a small knot on his head. She stated that Resident #1 appeared very jumpy and anxious when they entered the room. They reported the resident's injuries to LPN #1. She stated that Resident #1 had never hit or yelled at her before. On 2/26/25 at 2:26 PM in an interview with the Administrator, he stated that an investigator from corporate reviewed the investigation documentation, as well as himself and the DON, and they concluded that abuse was not substantiated. He also explained that CNA #1 had not returned to work since she was sent home that night due to the injury received from the resident biting her finger.

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	02/26/2025

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 0656 Level of Harm - Actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 44179 Based on interview, record review, and facility policy review, the facility failed to ensure comprehensive care plan interventions were implemented regarding a resident's behavior during care for one (1) of five (5) sampled residents when Certified Nurse Aide (CNA) #1 used physical force with Resident #1, who was cognitively impaired and had right Hemiparesis, was observed with purplish-red discoloration under the right eye, abrasions on the nose, and a hematoma on the forehead following an incident in which CNA #1 admitted to pressing down on Resident #1's left arm (the only functional arm) and using physical force on his face to prevent the resident from hitting her during care. Findings included: A review of the facility's policy, Comprehensive Care Plan, dated 03/2019, revealed, .It is the policy of this facility to .implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs .Policy Explanation and Compliance Guidelines .4. The care planning process will include an assessment of the resident's strengths and needs . A record review of the comprehensive care plan for Resident #1 revealed a Focus, initiated on 6/12/2023 of (Proper Name) has impaired cognitive function and impaired thought processes with an Intervention of COMMUNICATION: Use the residents name identify yourself at each interaction, Face The resident when speaking and make eye contact .the resident understands consistent, simple, directive sentences. Provide The resident with necessary cues - stop and return if agitated initiated on 6/12/2023, with the Position listed as CNA. (continued on next page)

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	02/26/2025

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 0656 Level of Harm - Actual harm Residents Affected - Few	A record review of the facility's investigation, dated 2/14/25, revealed that at approximately 1:30 AM on 1/9/2025, Licensed Practical Nurse (LPN) #1 reported that Resident #1 made an allegation of abuse related to CNA #1. The resident was immediately evaluated and interviewed by LPN #1 and sent out to the hospital for further evaluation. CNA #1 was questioned and sent home pending the outcome of the investigation. The staff wrote statements. The resident returned to the facility at 4:30 AM and was evaluated. He had bruising noted to right eye and hematoma noted to right side of head. Resident #1 stated that he hit the CNA first and he bit her after she hit him. The DON conducted a phone interview with Resident #1 who stated that she entered the room to help the resident prepare for bed and he needed to be changed. When she explained that he needed to be changed, he became aggressive and started swatting at her. She again explained to the resident the importance of getting cleaned up. She asked the resident to roll over so she could finish providing care and that's when the resident hit the CNA the first time. CNA #1 stated she put her hand up to prevent him from hitting her again. She admitted she did apply pressure to his arm. Resident #1 continued to be difficult. She stated at this time she called for help from CNA #2 was in the room assisting the resident's roommate. As she was calling for help, the resident bit her finger. CNA #1 said she placed her right hand up the resident's nose to see if he would let her finger go from his mouth. CNA #1 said the resident bit harder and then finally let go and she left the room. Resident #1 was interviewed and stated that he hit her first and bit her after she hit me. When asked what caused the event to happen, resident pointed to his private area. He then stated he did not want to be changed. Internal investigator revealed the allegation of abuse cannot be substantiated because Resident #1 was the aggressor, and staff was attempting to prevent the resident from hitting her again. A record review of the acute hospital documentation, dated 2/9/25, revealed, .Reportedly concern for patient being struck by an individual at nursing home facility. Patient has abrasion over right side of face as well as dried blood to left nostril .Discharge Diagnosis: Assault . A record review of the clinical profile revealed the facility admitted Resident #1 on 6/28/23 and he had diagnoses including Hemiplegia and Hemiparesis following Cerebral Infraction Affecting Right Dominant Side. A record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 11/28/24 revealed Resident #1 had a Brief Interview for Mental Status (BIMS) score of 7, which indicated his cognition was severely impaired. A review of Section B revealed his speech was unclear, and he is usually understood regarding his ability to express ideas and wants, and he usually understands verbal content from others. A review of Section E revealed he did not exhibit physical or verbal behaviors toward others and he had not exhibited any behaviors related to rejection of care. A review of Section GG revealed he had impairment on one side for the upper and lower extremity and he was dependent on staff for toileting hygiene. A review of Section H revealed he is always incontinent of urine. A review of Section I revealed a diagnosis of Hemiplegia or Hemiparesis. (continued on next page)

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	02/26/2025

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 0656 Level of Harm - Actual harm Residents Affected - Few	During a phone interview on 02/25/2025 at 9:53 AM, CNA #1 stated that when she entered Resident #1's room on 2/9/25, she was changing his brief and turned him on his side, but he repeatedly put his left arm in the way. CNA #1 explained that she applied her arm to his left forearm to prevent him from putting his hand in his genital area. She stated that Resident #1 continued to try to free his arm, and she applied more pressure to his forearm to complete the care. She noted that Resident #1 did not say anything during this interaction but continued to resist. While she was holding his forearm down, Resident #1 managed to get her finger into his mouth and began biting down on her finger. To get him to release her finger, CNA #1 stated that she placed her hand on his nose, hoping he would release her finger to breathe through his mouth, but instead, he bit down harder. CNA #1 stated that she had been trained to leave the room and notify the nurse if a resident refuses care. She reflected that, in hindsight, she should have stopped providing perineal care and left the room. On 02/26/2025 at 12:01 PM, during an interview, LPN #3, who is also responsible for MDS and Care Planning, stated that staff are expected to follow the resident's comprehensive care plan when providing care. She explained that Resident #1's comprehensive care plan directs staff to stop providing care if the resident becomes agitated and to return later to complete the care. She stated that CNA #1 did not follow the care plan as outlined. She emphasized that the care plan is resident-centered and individualized to meet the specific needs of the resident. On 02/26/2025 at 12:06 PM, during an interview, Registered Nurse (RN) #1, the MDS Coordinator, stated that the comprehensive care plan provides a detailed overview of the resident's care needs. She explained that it guides staff by providing a picture of the resident's specific needs and care requirements. On 2/26/25 at 12:55 PM, during an interview, the Director of Nursing (DON) stated CNA #1 should have left Resident #1's room when he became agitated and returned later to provide perineal care. The DON confirmed that CNA #1 did not implement the comprehensive care plan intervention to stop and return if agitated. She stated she expected the staff to follow the care plan to ensure residents get the highest quality of care they can based on the residents' medical conditions.