

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255326	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/04/2025
NAME OF PROVIDER OR SUPPLIER Pine Forest Health and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 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 - Minimal harm or potential for 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. (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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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review and facility policy review, the facility failed to implement the care plan for two (2) of (2) sampled residents related to participation in structured activities. (Resident #1 and Resident #2). Findings Include: A record review of the facility policy, Resident Rights & Dignity Management, revised 5/22, revealed on page 30: 1. The resident has a right to a dignified existence, self-determination and .3. Planning and Implementing Care .iv. The right to receive the services and/or items included in the care plan. On 9/3/25, between 9:33 AM and 11:30 AM, the State Agency (SA) observed Resident #1 in a Geri-chair and Resident #2 in a wheelchair sitting in the dayroom with no care planned or structured activity present. Neither one of the residents participated in an activity observed in the activity room at 10:35 AM. On 9/3/25 at 12:20 PM, both residents returned from lunch and again sat in the dayroom with no activities present. Later, at 1:25 PM, the SA observed a music activity occurring on the front patio; however, Resident #1 and Resident #2 were not present. The SA confirmed they remained in the dayroom, where they could neither see nor hear the activity. Following the music event, residents gathered for bingo. Staff transported Resident #1 to the dining room to sit with others during bingo. Observation showed her slouched in her Geri-chair, eyes closed, and not interacting. Resident #2 remained in the dayroom with no activities observed until the SA exited the facility at approximately 4:00 PM. On 9/4/25 at 8:27 AM, SA observed Resident #2 again sitting at an empty table in the dayroom with her back to the television and no structured activity occurring. On 9/4/25 at 10:01 AM, in an interview, Certified Nursing Assistant (CNA) #1 confirmed she had cared for Resident #1 for over a year. She stated that Resident #1 is nonverbal but appears to enjoy music when her family plays the radio in her room. She explained that bingo is not appropriate for her due to her inability to comprehend or participate meaningfully. On 9/4/25 at 10:14 AM, the Activities Director confirmed Resident #1 did not attend the music activity on 9/3/25 and stated, That was an oversight. She acknowledged the resident cannot comprehend bingo and said she only brought her to the game so she could be there. On 9/4/25 at 10:41 AM, during an interview, the Director of Nursing (DON) confirmed the SA's observation that Resident #2 had not been engaged in any activities and had been seated with her back to the television for several hours. The DON stated, She definitely needs to be in stimulating activities, and acknowledged a lack of follow-through by staff. On 9/4/25 at 10:48 AM, during an interview, the Administrator stated she expects structured activities to be provided daily for all residents, and that staff are expected to follow each resident's care plan, including the activities section. On 9/4/25 at 1:48 PM, during an interview, Licensed Practical Nurse (LPN) #1, who is responsible for care planning development, explained that the care plan is designed to meet residents' individualized needs and should be followed by all staff, including interventions related to activities. She stated that failure to follow the care plan could result in residents not receiving appropriate care. Resident #1A record review of the Care Plan Report with a date initiated of 7/15/22 for Resident #1 revealed Focus: She (Resident #1) enjoys visits from her sister and other family members, listening to music, devotions. Interventions: Encourage family visits and patient participation in daily group activities/programs with music therapy, movies, conversation. A record review of the admission Record revealed Resident #1 was admitted on [DATE] with diagnoses including Unspecified Focal Traumatic Brain Injury with Loss of Consciousness of 30 Minutes or Less, Sequela. A record review of the Quarterly MDS (Minimum Data Set) with an Assessment Reference Date (ARD) of 6/14/25 revealed a Brief Interview for Mental Status (BIMS) score of 0, indicating the resident could not participate in the interview. Resident #2A record review of the Care Plan Report revealed a care plan with a date initiated of 8/23/22 for Resident #2 Focus: (Proper name of Resident) takes pleasure in listening to classical music . Interventions. Staff will provide therapeutic activities for the resident to bring about a change. A record review of the admission Record revealed Resident #2 was admitted on [DATE] with diagnoses including Unspecified Dementia and Unspecified Psychosis. A record review of the Quarterly MDS with ARD of 7/16/25 revealed a BIMS score of 0, also indicating the resident could not participate in the interview.</p>		

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<p>F 0679</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide activities to meet all resident's needs.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, record review and facility policy review, the facility failed to ensure residents were provided with activities designed to meet their physical and mental needs and interest for two (2) of (2) residents reviewed for activities. (Resident #1 and Resident #2). Findings include: A review of the facility policy titled Resident Rights & Dignity Management, revised 5/22, stated on page 32: 6. Self-Determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to (a). The resident has the right to choose activities consistent with his or her interest, assessments, and plan of care. During an observation on 9/3/25, between 9:33 AM and 11:30 AM, the State Agency (SA) observed Resident #1 in a Geri-chair and Resident #2 in a wheelchair sitting in the dayroom with no care planned or structured activity present. Neither resident participated in an activity observed in the activity room at 10:35 AM. During an observation on 9/3/25 at 12:20 PM, observed Resident #1 and Resident #2 return from lunch and again sat in the dayroom with no activities present. Later, at 1:25 PM, the SA observed a music activity occurring on the front patio; however, Resident #1 and Resident #2 were not present. The SA confirmed they remained in the dayroom, where they could neither see nor hear the activity. Following the music event, residents gathered for bingo. Staff transported Resident #1 to the dining room to sit with others during bingo. Observation revealed Resident #1 slouched in her Geri-chair, eyes closed, and not interacting. Resident #2 remained in the dayroom with no activities observed until 4:00 PM. During an observation on 9/4/25 at 8:27 AM, the SA observed Resident #2 again sitting at an empty table in the dayroom with her back to the television and no structured activity occurring. During an interview on 9/4/25 at 10:01 AM, Certified Nursing Assistant (CNA) #1 confirmed she had cared for Resident #1 for over a year. She stated that Resident #1 is nonverbal but appears to enjoy music when her family plays the radio in her room. She explained that bingo is not appropriate for her due to her inability to comprehend or participate meaningfully. During an interview on 9/4/25 at 10:14 AM, the Activities Director confirmed Resident #1 did not attend the music activity on 9/3/25 and stated, That was an oversight. She acknowledged the resident cannot comprehend bingo and said she only brought her to the game so she could be there. During an interview on 9/4/25 at 10:41 AM, the Director of Nursing (DON) confirmed the SA's observation that Resident #2 had not been engaged in any activities and had been seated with her back to the television for several hours. The DON stated, She definitely needs to be in stimulating activities, and acknowledged a lack of follow-through by staff. During an interview on 9/4/25 at 10:48 AM, the Administrator stated that activities should occur daily for all residents. Resident #1A record review of the admission Record revealed Resident #1 was admitted on [DATE] with diagnoses including Unspecified Focal Traumatic Brain Injury with Loss of Consciousness of 30 Minutes or Less, Sequela. A record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 6/14/25 revealed a Brief Interview for Mental Status (BIMS) score of 0, indicating the resident could not participate in the interview. Resident #2A record review of the admission Record revealed Resident #2 was admitted on [DATE] with diagnoses including Unspecified Dementia and Unspecified Psychosis. A record review of the Quarterly MDS with an ARD of 7/16/25 revealed a BIMS score of 0, also indicating the resident could not participate in the interview.</p>		