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	12/09/2025

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 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. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	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 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 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