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	05/28/2026

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews, record reviews and facility policy review the facility failed to prevent the possibility of spreading infection during Activities of Daily Living (ADL) care for one (1) of four (4) care observations. Resident #7.Findings Include:Record review of facility policy Hand Hygiene with a revision date of 5/2023 revealed, .Staff involved in direct resident contact shall perform proper hand hygiene procedures to prevent the spread of infection to other personnel, residents, and visitors.On 5/27/26 at 3:00 PM, an observation of Activities of Daily Living (ADL) care was conducted for Resident #7 with Certified Nursing Assistant (CNA) #1. CNA #1 entered the resident's room carrying supplies and was not wearing a gown. She did not perform hand hygiene upon entering the room. CNA #1 donned (put on) gloves, informed the resident she would be providing care, adjusted the bed using the bed remote, and pulled back the bed sheet while wearing the same gloves. CNA #1 then removed her gloves and exited the room. CNA #1 returned to the room accompanied by the Respiratory Therapist (RT). Both staff members were wearing gowns upon reentry. CNA #1 did not perform hand hygiene upon entering the room before applying a new pair of gloves. While wearing clean gloves, she adjusted the bed using the bed remote and removed the television remote from the resident's bed. The RT changed the resident's tracheostomy dressing and assisted CNA #1 with turning the resident. CNA #1 removed the resident's gown, turned the resident onto his left side, and performed peri care. During the care, the resident's brief was observed to be soiled with urine. CNA #1 folded the soiled brief and tucked it underneath the resident. She subsequently adjusted the bed using the same contaminated gloves. A lift pad underneath the resident was observed to be yellow and soiled with urine. CNA #1 did not perform hand hygiene before providing care, during glove changes, or after completion of care. Upon completion, she removed her gloves, gathered supplies, and exited the room without performing hand hygiene.On 5/27/26 at 3:27 PM, during an interview, CNA #1 stated she did not know why she provided care in that manner and acknowledged she had made a mistake during peri care. CNA #1 stated the care she provided was an infection control concern and confirmed the resident could become ill as a result. She further confirmed she failed to perform hand hygiene before, during, and after resident care.On 5/27/26 at 4:44 PM, during an interview, Registered Nurse (RN) #1, who also served as the Infection Preventionist, stated CNA #1 had received training regarding hand hygiene. RN #1 stated CNA #1 should have performed hand hygiene upon entering the room, during care when contamination occurred, and upon exiting the room. RN #1 further stated the care observed could place the resident at risk for urinary tract infections, moisture associated skin damage, fungal infections, and cellulitis. RN #1 stated staff were expected to follow infection control practices and provide baseline standards of care.On 5/27/26 at 5:22 PM, during an interview, the Director of Nursing (DON) stated CNA #1 should have performed hand hygiene upon entering the room, during care activities, and after completion of care. The Director of Nursing stated when staff touch environmental surfaces or equipment while wearing contaminated gloves, they should remove the gloves, perform hand hygiene, and don clean gloves before resuming resident care. The DON confirmed residents could develop skin infections, wounds, and bacterial contamination when proper infection control practices are not followed. The DON stated she expected staff to provide care (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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	correctly to prevent residents from becoming ill.Record review of Resident #7's admission Record revealed an admission date of 4/17/26 with diagnoses that included tracheostomy status and dysphagia, oropharyngeal phase.Record review of Resident #7's Order Summary Report with active orders as of 5/27/26 revealed an order dated 4/17/26, Trach size #6 [NAME] flex tracheostomy with disposable inner cannula and an additional order for enteral feeding with Jevity 1.5 at 50 milliliters (ml) per hour with 100 ml water flushes every three hours.Record review of Resident #7's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 4/30/26 revealed a Brief Interview for Mental Status (BIMS) score of 99, indicating the resident was unable to complete the interview. Resident #7 was dependent upon staff for care.