| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 255326 | A. Building<br>B. Wing | 01/08/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Pine Forest Health and Rehabilitation | 1116 Forest Avenue<br>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) |
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| F 0580<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.<br><br>Based on facility policy review, record review and interview the facility failed to notify the Resident Representative (RR) of a change in condition for one (1) of four (4) sampled residents with falls. Resident #1. Findings Included:Record review of the facility provided Nursing Home Residents' Rights, undated, revealed Residents of nursing homes have rights that are guaranteed to them under Federal and State laws.Choice about designating a representative to exercise his or her rights.Right to be Fully Informed of.Changes to the plan of care, or in medical or health status.Record review of the facility policy titled, Resident Rights & Dignity Management with a revision date of September 2025 revealed .3. The resident has the right to be informed of, and participate in, his or her treatment, including c. The right to be fully informed.of his or her total health status, including but not limited to, his or her medical condition.The right to participate in the planning process.The right to be informed in advance, of the care to be furnished.Record review of the facility policy titled Falls Standard with Revision Date February 2018 revealed the policy stated, MEDICAL RECORD DOCUMENTATION GUIDELINES The INITIAL NOTE/ASSESSMENT SHOULD CONTAIN THE FOLLOWING AND INCLUDE A DESCRIPTION OF WHAT WAS DONE: A. Vital signs.Document who was notified and time of notification for all attempts to do so (e.g., physician, family, state agency, as appropriate) and Post Fall Process.Family is notified of event. Record review of the Facility Incident Report dated 12/28/25 for Resident #1 revealed the incident was categorized as an unwitnessed fall on 12/27/25 reported by Resident #1 with Resident #1's RR notified on 12/28/25 at 9:46 AM,Record review of the Facility Investigation dated 1/02/26 revealed Resident #1 reported to the Wound Care Nurse on 12/28/25 that she had fallen on the evening of 12/27/25 resulting in Resident #1's transportation to local emergency department for assessment and evaluation with radiographic diagnostics (CT scan of head). A written statement by Certified Nursing Assistant (CNA) #2 included in the Facility Investigation revealed that at approximately 7:48 PM on 12/27/25 she responded to call for help and observed Resident #1 on her stomach on the floor.On 1/07/26 at 11:20 AM during a telephone interview, the RR for Resident #1 stated she disapproved of and was disappointed with the facility nursing staff due to their failure to notify her of a fall experienced by Resident #1 on the evening of 12/27/25 and that she was not notified about until after 9:30 AM on 12/28/25. She stated that she was very concerned because Resident #1 had a bump on her right forehead and she had not received assessments or treatment until the following morning.On 1/07/26 at 2:25 PM, an interview with the Unit Manager, revealed that she was notified on 12/28/25 at approximately 9:20 AM by the Wound Care Nurse that Resident #1 reported that she had fallen and two staff had picked her up from the floor and put her back in the bed on the evening of 12/27/25 but the resident was unsure of the time. She stated that Resident #1's RR was notified of the fall at approximately 9:26 AM on 12/28/25. The Unit Manager stated that all of the actions and notifications were accomplished on 12/28/25 after the resident reported the fall to the Wound Care Nurse but should have been done on 12/27/25 as soon as possible<br><br>(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 0580<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | following the fall.On 1/07/26 at 2:50 PM, during an interview the Wound Care Nurse revealed she was notified by Resident #1 on 12/28/25 at approximately 9:18 AM that Resident #1 had fallen on the evening of 12/27/25 but was not able to recall the time and that she had hit her head on the floor and indicated the area by touching her forehead above her right eye. She stated that if a resident fell the RR should be notified right away as change of condition. She confirmed that the facility provided in-service training regarding Resident Rights and Facility Fall Policy and Procedure at least every month and that the in-service for Residents' Rights included notification of the Resident's RR in case of change of condition or incident or accident.On 1/07/25 at 3:00 PM, during an interview with Resident #1 and her RR in the resident's room, revealed Resident #1 reported that on the evening of 12/27/25 (she was unsure of the time) she fell from her bed when she reached down to get something off the floor and that she bumped her head. Resident #1 reported that staff responded to her call for help and assisted her back into bed. She said she told the Wound Care Nurse the next morning around 9:00 AM and was subsequently transported to the hospital for evaluation. The RR stated that she was not notified of the fall on 12/27/25 but was notified on 12/28/25 after Resident #1 reported the fall to the Wound Care Nurse. The RR confirmed that she observed a slightly swollen area on Resident #1's forehead just above her right eye on 12/28/25.On 1/07/26 at 3:20 PM, during an interview the Director of Nursing (DON) revealed that she was notified on 12/28/25 at approximately 9:23 AM by the Unit Manager via telephone that Resident #1 had reported to the Wound Care Nurse that she had fallen on the evening of 12/27/25 and hit her head and that the resident had a raised (inflamed/swollen), tender area on her right forehead. She confirmed that the correct procedure in case of a resident fall included notification of the resident's RR. The DON stated that Resident Rights included notification of resident RR upon change of condition, incident or accident.On 1/08/25 at 3:15 PM, during an interview CNA #1 reported that she was on duty at approximately 7:45 PM on 12/27/25 and observed Resident #1 lying on her face on the floor next to her bed. She stated that Licensed Practical Nurse (LPN) #1 instructed her and CNA #2 to assist the resident back into her bed. On 1/08/25 at 4:28 PM, during an interview with the Administrator she revealed she had been notified shortly after 9:00 AM on 12/28/25 by the DON that Resident #1 reported that she had a fall and bumped her head on the evening of 12/27/28. She stated she had interviewed Resident #1, who she confirmed had no cognitive or memory impairment, and that the resident confirmed that she had fallen and her head hit the floor. The Administrator confirmed that there was no documentation of notification of Resident #1's RR of 1/27/25 fall until 12/28/25 at 9:46 AM.Record review of the admission Record for Resident #1 revealed the facility admitted the resident on 7/18/25 and the resident had diagnoses of paraplegia and reduced mobility and lack of coordination.Record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) 10/25/25 for Resident #1 revealed the resident had a Brief Interview for Mental Status (BIMS) score of 14, which indicated the resident was cognitively intact. The MDS review revealed the resident was dependent for transfers and non-ambulatory (unable to walk). |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>Based on facility policy review, record review, and interviews the facility failed to evaluate, assess and identify potential injury for one (1) of four (4) residents who experienced a fall. Resident #1. Findings Included:Record review of the facility policy titled Falls Standard with Revision Date February 2018 revealed the policy stated, When a resident is found on the floor the facility is responsible for investing the reason for this.PROCEDURE POST-FALL.Obtain blood pressure and pulse while resident is on the ground.Do neuro-checks (assessment of resident's pupil equality and level of consciousness) for witnessed head injury or unwitnessed fall with or without injury. Move resident in bed or chair only if no obvious injury. Nursing to complete: Fall Risk Assessment form, Incident report.Accident/incident report, Post Fall Investigation report.MEDICAL RECORD DOCUMENTATION GUIDELINES The INITIAL NOTE/ASSESSMENT SHOULD CONTAIN THE FOLLOWING AND INCLUDE A DESCRIPTION OF WHAT WAS DONE: A. Vital signs.Document who was notified and time of notification for all attempts to do so (e.g., physician, family, state agency, as appropriate).At a minimum documentation is to be done every shift.Any negative change needs to be reported immediately.All incidents and accidents are reviewed in the daily morning clinical meeting to ensure the documentation and notification guidelines have been followed. FALLS STANDARD stated that EVENT of unwitnessed fall GUIDANCE included, Neurological assessment: Every 15 minutes X 2 hours then Every 30 minutes X 2 hours and then Every shift X 72 hours. Post Fall Process.Family is notified of event. Record review of the facility Incident Report dated 12/28/25 for Resident #1 revealed the incident was categorized as an unwitnessed fall on 12/27/25 as reported by Resident #1. The Director of Nursing (DON) was notified on 12/28/25 at 9:23 AM. Resident #1's Resident Representative (RR) was notified on 12/28/25 at 9:46 AM, and the Primary Healthcare Provider (Nurse Practitioner #1) was notified on 12/28/25 at 9:54 AM. The Incident Report included immediate action taken included some swelling to right forehead and tenderness and notification of ambulance service for transport with resident transported to acute care facility at 10:20 AM on 12/28/25. Record review of the Facility Investigation dated 1/02/26 revealed Resident #1 reported to the Wound Care Nurse on 12/28/25 that she had fallen on the evening of 12/27/25 resulting in Resident #1's transportation to the local emergency department for assessment and evaluation with radiographic diagnostics Computed Tomography (CT) scan of the head. A statement written statement by Certified Nursing Assistant (CNA) #2 in the Facility Investigation revealed she stated that at approximately 7:48 PM on 12/27/25 she responded to call for help and observed Resident #1 on her stomach on the floor.On 1/07/26 at 11:20 AM, during a telephone interview the RR for Resident #1 stated she disapproved of and was disappointed with the facility nursing staff due to their failure to notify her of a fall experienced by Resident #1 on the evening of 12/27/25 that she was not notified about until after 9:30 AM on 12/28/25. She stated that she was very concerned because Resident #1 had a bump on her right forehead and she had not received assessments or treatment until the following morning.On 1/07/26 at 2:25 PM, during an interview with the Unit Manager, revealed that she was notified on 12/28/25 at approximately 9:20 AM by the Wound Care Nurse that Resident #1 reported that she had fallen and two staff had picked her up from the floor and put her back in the bed on the evening of 12/27/25 but the resident was unsure of the time. She stated that her immediate reaction was to conduct a body audit and pain assessment on the resident, who reported forehead tenderness at the site of swelling over right eye and that she had hit her head during the fall. The Unit Manager stated that she observed some swelling above the resident's right eye. She stated that neuro-checks and vital sign checks were initiated according to the facility policy and procedure for unwitnessed falls. She stated that Resident #1's Primary Healthcare Provider Nurse Practitioner (NP) #1 was<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | notified of the fall at approximately 9:54 AM on 12/28/25 and the RR was notified of the fall at approximately 9:26 AM on 12/28/25. The Unit Manager stated that all of the actions and notifications were accomplished on 12/28/25 after the resident reported the fall to the Wound Care Nurse should be done on 12/28/25 as soon as possible following the fall. She confirmed that monitoring should have included neuro-checks, pain assessment and vital signs monitoring, which were not performed or documented following the incident during the 3:00 PM to 11:00 PM shift on 12/27/25, or during the 11:00 PM to 7:00 AM shift.On 1/07/26 at 2:50 PM, during an interview the Wound Care Nurse revealed she was notified by Resident #1 on 12/28/25 at approximately 9:18 AM that Resident #1 had fallen on the evening of 12/27/25 but was not able to recall the time and that she had hit her head on the floor and indicated the area by touching her forehead above her right eye. She stated that falls had to be reported and documented on the Twenty-Four-Hour Report, with an incident report completed in the resident's medical record for continuity of care and assessments, and included vital signs and neurological checks, for residents who had fallen. She stated that if a resident fell the RR should be notified right away as change of condition. She confirmed that the facility provided in-service training regarding Resident Rights and Facility Fall Policy and Procedure at least every month and that the in-service for Residents' Rights included notification of the Resident's RR in case of change of condition or incident or accident.On 1/07/25 at 3:00 PM, during an interview with Resident #1 and her RR in the resident's room revealed Resident #1 reported that on the evening of 12/27/25 (she was unsure of the time) she fell from her bed when she reached down to get something off the floor and that she bumped her head. Resident #1 reported that staff responded to her call for help and assisted her back into bed. She said she told the Wound Care Nurse the next morning around 9:00 AM and was subsequently transported to the hospital for evaluation. The RR stated that she was not notified of the fall on 12/27/25 but was notified on 12/28/25 after Resident #1 reported the fall to the Wound Care Nurse. The RR confirmed that she observed a slightly swollen area on Resident #1's forehead just above her right eye on 12/28/25.On 1/07/26 at 3:20 PM, during an interview with the DON revealed that she was notified on 12/28/25 at approximately 9:23 AM by the Unit Manager via telephone that Resident #1 had reported to the Wound Care Nurse that she had fallen on the evening of 12/27/25 and hit her head and that the resident had a raised (inflamed/swollen), tender area on her right forehead. She stated she instructed that a body audit and neurological assessments (every 15 minutes X4, every 30 minutes X4 and then every hour X8 and then every shift) be completed with on-going assessment for seventy-two hours after fall per facility policy and procedure/fall protocol. She stated the RR for Resident # 1, telephoned her on the morning of 12/28/25 and was upset and crying and said she had been notified on the morning of 12/28/25 that the resident had fallen. The DON stated that the facility initiated and completed an investigation into the incident because the resident fell. The DON confirmed that failure to report incidents and provide assessments and care as needed according to facility policy and procedure for falls could result in the resident having unrelieved pain, complications, or negative unidentified results from falls. She confirmed that the correct procedure in case of a resident fall was to assess the resident including body/skin audit and pain assessment, if safe assist the resident to a position of comfort, begin routine neurological assessments (neuro-checks) and vital sign monitoring for seventy-two hours, notify the resident's Primary Healthcare Provider (PHP) and RR, the DON and Administrator and the ambulance if needed. The DON stated that the primary health care provider (PHP) for Resident #1 ordered radiographic diagnostics. The DON stated that Resident Rights included notification of resident RR upon change of condition, incident or accident. The DON stated that the failure of the facility nursing staff delayed notification of Resident #1's PHP. She<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | confirmed that the Staff Educator initiated in-service training on 12/28/25 for all nursing staff that included Resident Rights and facility fall policy and procedure because of the 12/27/25 incident that included instructions regarding notification of resident representatives of all falls and correct protocol following falls to include assessments, evaluation, documentation and reporting.On 1/08/25 at 3:15 PM, during an interview CNA#1 reported that she was on duty at approximately 7:45 PM on 12/27/25 and observed Resident #1 lying on her face on the floor next to her bed. She stated that Licensed Practical Nurse (LPN) #1 instructed her and CNA #2 to assist the resident back into her bed. On 1/08/25 at 4:28 PM, an interview with the Administrator revealed she had been notified shortly after 9:00 AM on 12/28/25 by the DON that Resident #1 reported that she had a fall and bumped her head on the evening of 12/27/28. She stated she had interviewed Resident #1, who she confirmed had no cognitive or memory impairment, and that the resident confirmed that she had fallen and her head came in contact with the floor. The Administrator confirmed that there was no documentation of fall or appropriate assessment or evaluation, and nursing staff had not followed facility policy or protocol for falls and had not reported the fall to the RR or PHP.Record review of the admission Record for Resident #1 revealed the facility admitted the resident on 7/18/25 with diagnoses that included paraplegia and reduced mobility and lack of coordination.Record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 10/25/25 for Resident #1 revealed the resident had a Brief Interview for Mental Status (BIMS) score of 14, which indicated the resident was cognitively intact. The MDS review revealed the resident was dependent for transfers and non-ambulatory (unable to walk). |