

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255326		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/16/2026	
NAME OF PROVIDER OR SUPPLIER PINE FOREST HEALTH AND REHABILITATION				STREET ADDRESS, CITY, STATE, ZIP CODE 1116 FOREST AVENUE , JACKSON, Mississippi, 39206			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F0000	INITIAL COMMENTS The State Agency (SA) conducted three (3) Complaint Investigations (CI MS# 3053430, CI MS# 3055083 and CI MS #3093491) at the facility from 7/15/26 through 7/16/26. CI MS #3053430 was investigated regarding accidents, quality of care and neglect and Incident #3093491 was investigated regarding accidents/incidents with no deficiencies cited. CI MS# 3055083 was investigated regarding physical environment. During the survey, the SA determined the facility was not in compliance with the requirements for participation in Medicare and Medicaid for CI MS# 3055083 with two (2) deficiencies cited, F0558 and F0921. The facility held a license for 120 beds, with a census of 98.			F0000			
F0558 SS = D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is NOT MET as evidenced by: Based on observations, interviews, record reviews, and facility policy review, the facility failed to ensure the call lights were within reach for two (2) of five (5) residents, Resident #1 and Resident #2. Findings Included: Review of the facility policy titled "Call Light Standard" with revision date 03.2019 (March 2019) revealed, "The purpose of this standard is to assure the facility is adequately equipped with a call light at each resident's bedside...to allow residents to call for assistance...1. All staff will be educated on the proper use of the resident call system, including how the system works and ensuring resident access to the call light...5. With each interaction in the resident's room or bathroom, staff will ensure the			F0558			

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 reverse for further 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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F0558 SS = D	Continued from page 1 call light is within reach of resident and secured, as needed..." On 7/15/26 at 12:22 PM observation of Resident #1 and Resident #2 revealed the call light system devices were not accessible to either resident while in their beds, as the devices were laying on the floor between their beds. Resident #2 attempted to reach his call light and was unable to locate or reach it. On 7/15/26 at 4:10 PM observation of Resident #1 and Resident #2 in their room revealed the call light system devices were laying coiled on the floor between their beds beneath the call light system outlet. Neither resident was able to reach his call light device or its cord from their respective beds, where they were resting. On 7/16/26 at 12:55 PM observation of Resident #1 and Resident #2 with the Administrator in their room revealed both residents were resting on their respective beds and the call light system devices were laying coiled on the floor between their beds beneath the call light system outlet. Neither resident was able to reach his call light device or its cord. The Administrator positioned each resident's call light within their reach. On 7/16/26 at 2:40 PM interview with Licensed Practical Nurse (LPN) #1 revealed she stated that all residents call light system devices were supposed to be positioned within their reach to summon assistance as needed. On 7/16/26 at 2:50 PM interview with Certified Nursing Assistant (CNA) #1 revealed she said call lights "should be kept within reach of the resident...so if they need help, they will be able to call". She said that she made rounds every two hours to check on her assigned residents. On 7/16/26 at 2:57 PM interview with Registered Nurse (RN) #1 revealed call lights were to be left within reach of each resident. She confirmed that the nurses were responsible for supervising resident care and that all staff were responsible for call lights being left within residents' reach upon the conclusion of each interaction and during regular rounds. On 7/16/26 at 3:00 PM interview with the Administrator revealed she stated that all residents call light system devices were supposed to be positioned within their reach to summon assistance as needed. She said that all staff were responsible for making sure that residents could reach their call	F0558					

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F0558 SS = D	Continued from page 2 lights. Record review of the Admission Record for Resident #1 revealed the facility admitted him on 5/20/25 and he had diagnoses of dysphagia, gastrostomy, type 2 diabetes, chronic obstructive pulmonary disease (COPD) and repeated falls. Record review of the Quarterly Minimum Data Set (MDS) with Assessment Reference Date (ARD) 4/24/26 for Resident #1 revealed a Brief Interview for Mental Status (BIMS) score of 07, which indicated severe cognitive impairment, and that the resident was dependent for toilet hygiene, and required partial/moderate assistance for chair/bed to chair transfers and could not walk without assistance. Record review of the Admission Record for Resident #2 revealed the facility admitted him on 7/11/26 and he had diagnoses of malignant neoplasm of hypopharynx, anemia, COPD, lack of coordination, abnormal gait and weakness. Record review of the Quarterly MDS with ARD 6/15/26 for Resident #2 revealed a BIMS score of 10, which indicated moderate cognitive impairment, and he was dependent for toilet transfers.	F0558					
F0921 SS = D	Safe/Functional/Sanitary/Comfortable Environ CFR(s): 483.90(i) §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, record review, and policy review, the facility failed to maintain a safe, functional, and comfortable kitchen environment for staff and failed to ensure the kitchen's air-conditioning system was repaired promptly. The deficient practice had the potential to affect all residents served by the facility's dietary department and all dietary staff required to work in the kitchen while the air-conditioning system remained inoperable. Findings include: Review of the facility policy titled, "Capital Improvements" dated 08.2021 (August 2021) revealed, "It is the standard of this facility to adhere to	F0921					

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F0921 SS = D	Continued from page 3 applicable Federal Health care program requirements...pertaining to capital equipment and supplies...The Plant Operations Manager or designee conducts or obtains certain maintenance and repair functions according to regular schedule or as the need is determined..." During Environmental Observations on 7/15/26 at 11:55 AM and 7/16/26 at 1:00 PM SA determined that the facility kitchen air conditioner was not working, and the dietary department staff were required to substitute hot menu items with food items that could be prepared/served cold due to excessive heat in the kitchen. On 7/15/26 fried chicken was not served. On 7/16/26 at 1:05 PM observation and interview with Cook #1 and Cook #2 revealed there was a large industrial fan positioned toward the open doorway to direct cool air from the dining room into the kitchen. When asked why the fan was there kitchen and how long it had been there, both explained that the A/C unit in the kitchen was not working properly and the fan had been there since Monday 7/13/26. Both described the heat in the kitchen as oppressive. When SA expressed concern and cautioned against getting too hot, Cook #2 reported that she became unwell following her shift in the kitchen on 7/12/26 and missing work on 7/13/26. Both confirmed that the excessive outdoor heat with the heat index reaching into the triple digits were not helping matters. When asked why fried chicken was removed from the menu on 7/15/26, they explained that food items had to be substituted to prevent overheating the kitchen by use of heat-generating appliances for food preparation. While neither staff member sought SA to report complaints, they answered questions with open demeanors. On 7/16/26 at 1:23 PM interview with the Plant Operations Manager (Maintenance Supervisor) revealed that the malfunction of the kitchen A/C unit was an ongoing problem for which he had sought repair services. He said that the unit may need to be replaced. He confirmed that the large industrial fan positioned toward the propped open doorway to direct cool air from the dining room into the kitchen had been placed there by maintenance staff to help prevent overheating the kitchen. He said he didn't always attend the morning meetings due to emergent needs elsewhere in the facility and was unaware that the menu items had been substituted to help prevent overheating the kitchen. He confirmed that he was aware of federal and state regulations that stated that the facility was required			F0921			

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F0921 SS = D	Continued from page 4 to provide a safe and functional environment for residents and staff. On 7/16/26 at 2:30 PM interview with the Dietary Manager revealed that she had reported hot conditions in the kitchen during the morning meetings and that one dietary staff member who had worked during the day on Sunday 7/12/26 had called in to report she was unable to work on Monday 7/13/26 due to illness. She reported that the excessive heat in the kitchen due to the malfunction of the A/C unit had resulted in 1.) dietary having to take frequent breaks to go outside or into the dining room to ensure they didn't overheat and 2.) dietary services had to begin serving food item substitutions to residents in an effort to prevent generation of additional heat in the kitchen by heat-generating appliances, such as the deep fryer, steam table, oven and stove. She specified that the menu had been changed for 7/15/26 and 7/16/26. She confirmed that the door between the dining room and kitchen had been propped open and a large industrial fan positioned toward the open doorway to direct cool air from the dining room into the kitchen on 7/15/26 and 7/16/26, "trying to make sure the staff don't overheat". On 7/16/26 at 2:35 PM interview with the Director of Nurses (DON) confirmed that the Dietary Manager had reported increased temperature (heat) in the kitchen during morning meetings in June and July 2026. She confirmed that the door between the dining room and kitchen had been propped open and a large industrial fan positioned toward the open doorway to direct cool air from the dining room into the kitchen on 7/15/26 and 7/16/26. On 7/16/26 at 3:00 PM interview with the Administrator revealed that the facility had been aware of the issues with the kitchen air conditioning (A/C) unit since 6/22/26 and that the contract air conditioning service company that was on their vendors' list had visited the facility the week of 6/22/26 and addressed the problem. The Administrator confirmed that the repair had not completely corrected the issue and that the problems with the unit had resumed. She said she had been on vacation 7/13/26 through 7/15/26 and was aware on 7/10/26 that there was a malfunction with the air conditioning unit in the kitchen. She stated that because the facility contract A/C service had visited several times and the unit was still not working properly, she was attempting to get another contract A/C service added to the facility's approved vendors' list but that had not happened. She was not sure when the last time the current A/C			F0921			

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F0921 SS = D	Continued from page 5 service had been contacted to come to the facility to evaluate and repair the kitchen A/C unit. Record review of the weather report at https://www.msn.com/en-us/weather/monthlyforecast/in-Jackson,MS and the National Weather Service outdoor high temperature on 7/15/26 was 90 degrees Fahrenheit with a heat index, a measure of temperature as perceived by humans that combines actual air temperature and humidity and on 7/16/26 it was 91 to 92 degrees Fahrenheit and the city had an active heat alert in effect. Record review of the invoice dated 7/16/26 from the contracted A/C service revealed Invoice 21114 stated, "Kitchen A/C not working...unit not coming on due to bad delay timer for compressor. Bypassed timer. Then checked operation of unit. Checked pressures, supply and return temps. Operating normal at this time.".			F0921			