

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 08/19/2026	
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 two (2) Complaint Investigations (CI MS #3117793 and CI MS #3152582) at the facility from 8/18/26 through 8/19/26. During the survey, the SA determined the facility was not in compliance with the requirements for participation in Medicare and Medicaid. CI MS #3117793 was investigated related to quality of care/treatment, accidents/fall, and residents' rights and F657 was cited. CI MS #3152582 was investigated regarding administration, residents' rights and neglect and cited F553 and F573. The facility held a license for 120 beds, with a census of 105.			F0000			
F0553 SS = D	Right to Participate in Planning Care CFR(s): 483.10(c)(2)(3) §483.10(c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to: (i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care. (ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care. (iii) The right to be informed, in advance, of changes to the plan of care. (iv) The right to receive the services and/or items included in the plan of care. (v) The right to see the care plan, including the right to sign after significant changes to the plan of care.			F0553			

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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F0553 SS = D	Continued from page 1 §483.10(c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must- (i) Facilitate the inclusion of the resident and/or resident representative. (ii) Include an assessment of the resident's strengths and needs. (iii) Incorporate the resident's personal and cultural preferences in developing goals of care. This REQUIREMENT is NOT MET as evidenced by: Based on facility policy review, record review and interviews, the facility failed to ensure the Resident Representative (RR) was included in the development of the care plan for one (1) of four (4) sampled residents. Resident #1. Findings Included: Record review of the facility document titled, "NURSING HOME RESIDENTS' RIGHTS" undated revealed "Residents of nursing homes have rights that are guaranteed to them under Federal and State laws...Right to Self Determination...Participate in developing and implementing a person-centered plan of care...Right to be Fully Informed of the type of care to be provided...Changes to the plan of care..." Record review of the facility policy "COMPREHENSIVE CARE PLAN" with a revision date of July 2026 revealed, "The comprehensive care plan shall describe...Resident specific interventions that reflect the resident's needs...The comprehensive care plan shall be prepared by an interdisciplinary team, that includes...The resident and the resident's representative...The comprehensive care plan shall be reviewed and revised by the interdisciplinary team after each comprehensive and quarterly Minimum Data Set (MDS) assessment...The physician, other practitioner, or professional shall inform the resident and/or representative of the risks and benefits of proposed care, of treatment, and treatment alternatives/options..." On 8/18/26 at 9:33 AM, during a telephone interview the Complainant for CI MS # 3152582, the RR for Resident #1 said she had not been notified of a care plan meeting since she was designated as Resident #1's RR and was unaware of any care plan meeting in 2026, although she had requested a care plan	F0553					

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

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F0553 SS = D	Continued from page 2 meeting multiple times, verbally and in writing. On 8/19/26 at 12:35 PM, during an interview the Director of Nurses (DON) confirmed that Resident #1's last care plan meeting was held on 2/10/26 with his former RR in attendance. On 8/19/26 at 12:50 PM, during an interview MDS Nurse confirmed that care plan meetings were usually held every three (3) months following Quarterly (or Annual) MDS assessments and as needed upon significant change of resident condition/plan of care or resident or RR request. On 8/19/26 at 3:20 PM, during an interview the Administrator revealed that she was aware that the RR for Resident #1 had changed "in January or February 2026". She confirmed that Resident #1 had quarterly MDS assessment in May 2026 and that care plan meetings were normally scheduled every three months following the MDS assessment. She confirmed that she had received requests from Resident #1's current RR for a care plan meeting and that none had been conducted or scheduled until August 2026. She confirmed that Resident #3 had a significant change of condition in July 2026. She confirmed that residents and/or their RRs had the right to participate in care planning activities. On 8/19/26 at 3:50 PM, interview with the Social Servies Director, (SSD) revealed that she scheduled quarterly care plan meetings with the resident and/or their RRs, usually following the quarterly MDS assessment or as needed or upon request of the resident or their RR. She confirmed that the last care plan meeting for Resident #1 was held 2/10/26 and attended by his former RR. Record review of the "Admission Record" for Resident #1 revealed an admission date of 12/11/24 with an original admission date of 8/07/23 with diagnoses that included hemiplegia and hemiparesis and aphasia following cerebral infarction (stroke).	F0553					
F0573 SS = D	Right to Access/Purchase Copies of Records CFR(s): 483.10(g)(2)(i)(ii)(3) §483.10(g)(2) The resident has the right to access personal and medical records pertaining to him or herself. (i) The facility must provide the resident with access to personal and medical records pertaining to him or herself, upon an oral or written request, in the form and format requested by the individual, if it is readily	F0573					

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F0573 SS = D	Continued from page 3 producible in such form and format (including in an electronic form or format when such records are maintained electronically), or, if not, in a readable hard copy form or such other form and format as agreed to by the facility and the individual, within 24 hours (excluding weekends and holidays); and (ii) The facility must allow the resident to obtain a copy of the records or any portions thereof (including in an electronic form or format when such records are maintained electronically) upon request and 2 working days advance notice to the facility. The facility may impose a reasonable, cost-based fee on the provision of copies, provided that the fee includes only the cost of: (A) Labor for copying the records requested by the individual, whether in paper or electronic form; (B) Supplies for creating the paper copy or electronic media if the individual requests that the electronic copy be provided on portable media; and (C) Postage, when the individual has requested the copy be mailed. §483.10(g)(3) With the exception of information described in paragraphs (g)(2) and (g)(11) of this section, the facility must ensure that information is provided to each resident in a form and manner the resident can access and understand, including in an alternative format or in a language that the resident can understand. Summaries that translate information described in paragraph (g)(2) of this section may be made available to the patient at their request and expense in accordance with applicable law. This REQUIREMENT is NOT MET as evidenced by: Based on facility policy review, record review and interviews, the facility failed to ensure the residents' right to access the medical records for one (1) of four (4) sampled residents. Resident #1. Findings Included: Record review of the facility document titled, "NURSING HOME RESIDENTS' RIGHTS" undated revealed "Residents of nursing homes have rights that are guaranteed to them under Federal and State laws...Right to Self Determination...Participate in developing and implementing a person-centered plan of care...Right to be Fully Informed of the type of care to be provided...Changes to the plan of			F0573			

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F0573 SS = D	Continued from page 4 care..." Record review of the facility policy, "MEDICAL RECORD REQUESTS", undated, revealed, "Medical records will be released with a valid request and in accordance with state and federal laws...6. Upon receipt of a request for medical record copies, the facility should notify the requesting party, in writing, of the cost for obtaining records and that records are available 5 business days after receipt of payment for the copies...Access Rights to Medical Information are as follows: The resident (current) resident – the resident's record is accessible to him/her within 24 hours (excluding weekends and holidays) notice, following written request..." On 8/18/26 at 9:33 AM, during a telephone interview the Complainant for CI # 3152582 the Resident Representative (RR) for Resident #1 reported the facility had actively obstructed the resident rights of Resident #1. She said she had been designated as the conservator for Resident #1 in January 2026 and presented the documentation to the facility and was therefore designated as the RR for Resident #1. She said she had completed and submitted a written request on 7/02/26 to inspect and obtain the clinical records of Resident #1. She reported that after the facility ignored written requests for 35 days, she went to the facility in person 8/06/26 and was granted access to electronic records. She said the Assistant Director of Nursing (ADON) claimed that electronic access to clinical logs was not available on-site after 30 days and required a corporate request. She said the administration refused to produce her brother's treatment records/therapy records and shower schedules documentation and claimed they "do not have access to those on the computer." Record review of the "Request to Inspect Medical Records" dated 7/02/26 revealed the RR for Resident #1 requested medical records "6/30/26-7/02/26...nursing notes, respiratory notes for dates 6/30-7/2/26... and 07/2/2025...shower schedule for the month of June 2026 and July 2026...schedule that (Resident #1) is gotten out of the bed for activities or therapy for June and July..." Record review of the email response from the "Shareholder and ...Arbitrator" to the RR for Resident #1 dated 8/6/26 revealed, "... I am providing to you a copy of (Resident #1's) Progress Notes for 6/30/2026-7/2026, which includes Respiratory..." On 8/19/26 at 12:35 PM, during an interview the Director of Nurses (DON) confirmed that she			F0573			

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F0573 SS = D	Continued from page 5 received a request for records for Resident #1 by his RR on 7/02/26. She said she provided Resident #1's RR with the facility policy on record requests and asked her to complete a records request form, which was completed and that the RR had included a typed list of her requests to be included or attached. She said that the RR was allowed to view Resident #1's electronic records accompanied by facility staff for an extended period of at least an hour and a half on 8/06/26. She said that according to facility policy and confirmed that some of the records the RR had requested for review were not available at the facility. On 8/19/26 at 2:20 PM, during an interview with the RR for Resident #1, she confirmed she had spoken with the DON on 7/02/26 and requested access to inspect Resident #1's medical records and that on 8/06/26 she was allowed to view his records with nursing staff for thirty minutes. She stated that she received only nursing progress notes from the corporate office for 6/30/26 through 7/02/26 and nothing more than 8/19/26. On 8/19/26 at 3:20 PM, during an interview the Administrator revealed that she was aware that the RR for Resident #1 had changed "in January or February 2026". She confirmed that on 7/02/26 she had received a verbal and written request for records from the RR for Resident #1 and on 8/10/26 received a certified letter that some of the requested records still had not been provided as of 8/19/26, including care records for 6/30/25 through 7/02/25. The Administrator confirmed that the Resident's RR had not received copies of all requested medical records for Resident #1 as of 8/19/26. She confirmed that the resident and/or their representative had the right to access the residents' medical records within (24) business hours of verbal or written request and copies of the resident's medical records within two business (2) days, assuming cooperation with the allowable fees. Record review of the "Admission Record" for Resident #1 revealed the facility admitted him on 12/11/24 with an original admission date of 8/07/23 with diagnoses that included and he had diagnoses of hemiplegia and hemiparesis and aphasia following cerebral infarction (stroke).			F0573			
F0657 SS = D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans			F0657			

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F0657 SS = D	Continued from page 6 §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is NOT MET as evidenced by: Based on observation, facility policy review, record review and interviews, the facility failed to update the resident's care plan after a fall to prevent recurrence for one (1) of four (4) sampled residents. Resident #3. Findings Included: Record review of the facility policy, "Falls Standard" with a revision date of May 2026, revealed, "POST FALL STANDARD...Revise/update intervention on the Plan of Care" and included "FALLS: DECISION TREE...Step 3 Has the resident just fallen? ->Step 4 Evaluate the factors associated with the fall. ->Step 5 Identify the resident's actual and potential complications of falls. -> Step 6 Develop a plan for managing falls and fall risks..." Record review of the facility policy, "COMPREHENSIVE CARE PLAN" with a revision date of July 2026 revealed, "... 3. The comprehensive care plan shall describe...f. Resident specific interventions that reflect the resident's needs..."	F0657					

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F0657 SS = D	Continued from page 7 Record review of the "Care Plan Report" for Resident #3 revealed, "Focus... At risk for Falls...06/21/2026 Fall with no injuries...Interventions/Tasks...Send to RE related to a fall. Date Initiated 06/21/2026..." There were no updated interventions or revisions that addressed the cause of the 6/21/26 fall or prevention of future falls based on the incident report root cause analysis conducted by the facility dated 6/21/26. Record review of the "Progress Notes *NEW* dated 6/21/26, Type: Post Fall Evaluation, revealed she experienced a fall from her bed with the reason for the fall: Resident's bed was sitting up in high fowlers. On 8/18/26 at 1:30 PM, observation, record review and interview with Certified Nursing Assistant (CNA) #1 revealed that she and Licensed Practical Nurse (LPN) #1 transferred Resident #3 into bed from her wheelchair following lunch. The side rails were in place and up and head of bed elevated to high fowler's position (head of bed elevated in an upright position). She then demonstrated the use of the facility laptop to review care instructions for Resident #3. CNA #1 confirmed there were no instructions regarding partial side rails or positioning Resident #3 to prevent a fall. On 8/19/26 at 12:35 PM, during an interview the Director of Nurses (DON) revealed Resident #3 had a fall from bed on 6/21/26, after which the facility had completed an incident report, conducted a root cause analysis and determined the cause of the fall, and that the resident's fall care plan had not been updated with an intervention directed at prevention of further falls. She explained that the root cause of the fall was determined to be that the resident was left with her bed in high fowler's position (head of bed elevated in an upright position). She confirmed that the only intervention added stated, "Send to RE related to a fall. Date Initiated:6/21/26" which did not address the cause of the resident's fall or interventions to prevent further falls. The DON confirmed that the care plan should be updated following any incident/fall and should include/update interventions to address the cause and prevent further falls. She confirmed that the facility procedure included review of and notification of the MDS Nurse of all incidents/falls during the daily clinical meetings and that the MDS Nurse was responsible for updating the care plan but confirmed that any nurse could update the care plan. She explained that the Individual Care Service Plan (ICSP) was pulled directly from the care plan to provide			F0657			

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F0657 SS = D	Continued from page 8 care instructions for each resident to all CNAs and was available to them on laptops or tablets, therefore if interventions to prevent falls were not added to a care plan, they were also not listed in the resident's ICSP. She confirmed that the resident was transferred to local ER (emergency room) for evaluation and treatment as needed and returned without hospital admission and no new diagnoses or physician orders and that Resident #3 had not experienced any falls since 6/21/26. On 8/19/26 at 12:50 PM, interview with the Minimum Data Set (MDS) Nurse revealed that the only revision or update to the care plan of Resident #3 following 6/21/26 fall was "Send to RE related to a fall. Date Initiated:6/21/26" and that intervention did not address the cause of the resident's fall or interventions to prevent further falls. On 8/19/26 at 3:20 PM, interview with the Administrator revealed she expected nursing staff to complete a review of all incidents including falls during daily clinical meetings and update resident care plans as needed in response and include interventions that addressed the cause of the fall and prevention of future falls. She confirmed that updating and revising care plans as needed according to facility policies on falls and care plans provided necessary care instructions for nursing staff and protection for residents. Record review of the "Admission Record" for Resident #3 revealed the resident was admitted to the facility on 8/06/23 with an original admission date of 7/15/16 with diagnoses that included intracerebral hemorrhage onset 8/25/21 and dementia onset 9/27/18. Record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 6/17/26 revealed a Brief Interview for Mental Status (BIMS) score of 3, which indicated severe cognitive impairment.			F0657			