

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255210		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 09/24/2026	
NAME OF PROVIDER OR SUPPLIER PINE CREST GUEST HOME INC				STREET ADDRESS, CITY, STATE, ZIP CODE 133 PINE STREET , HAZLEHURST, Mississippi, 39083			
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F0000	INITIAL COMMENTS The State Agency (SA) conducted an Annual Recertification survey along with one (1) Complaint Investigation (CI MS #3171942) at the facility from 09/21/26 through 09/24/26. The SA determined the facility was not in compliance with the requirements of participation in Medicare and Medicaid for CI MS #3171942 which was investigated for Quality of Care and F0600 and F0609 were cited. There were no citations for the annual recertification survey. The facility had a census of 47 and was licensed for 55 beds.			F0000			
F0600 SS = G	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, record review, and facility policy review, the facility failed to ensure one (1) of two (2) residents reviewed for accidents and hazards was free from neglect when the facility failed to respond appropriately after Certified Nursing Assistant (CNA) #1 discovered Resident #41 on the floor in her room. Specifically, CNA #1 assisted Resident #41 from the floor back to bed			F0600			

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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F0600 SS = G	Continued from page 1 without notifying a nurse, obtaining a nursing assessment, summoning additional assistance, or using a mechanical lift, despite the resident's history of falls and the potential for injury following a fall. The failure to report the incident resulted in a delay of approximately one day in Resident #41's assessment, diagnostic evaluation, and treatment. Resident #41 subsequently complained of increasing pain and swelling, and an X-ray performed on 8/19/26 identified acute fracture of the right distal tibia. The Nurse Practitioner (NP) confirmed the delay in evaluation and treatment placed Resident #41 at risk for worsening of the fractures, compound fracture, pulmonary fat embolism, and untreated pain. Findings Include: Record review of the facility policy "Incident and Accident Reporting " revised 9/5/26 revealed "It is the policy of this facility that everything possible should be done to avoid accidents or incidents involving patients, guests, or employees of this facility. An incident report records details of an accident, injury, workplace incident, security breach, or any other type of unforeseen event..." During an initial observation and interview on 09/21/26 at 2:19 PM, Resident #41 was seated in a wheelchair with her swollen right leg elevated on a leg rest. Resident #41 stated she had recently fallen and broken her leg and did not know what caused the fracture. During an interview on 09/23/26 at 9:41 AM, Certified Nursing Assistant (CNA)#1 stated she worked the night shift on 08/17/26 and found Resident #41 on the floor in her room, resting on her knees on top of pillows and attempting to pull herself up by the bed. CNA #1 stated Resident #41 begged her to return her to bed and not tell anyone because of the resident's history of repeated falls. CNA #1 stated she asked Resident #41 if she was all right, and the resident denied pain. CNA #1 stated she assisted Resident #41 to stand and return to bed without notifying a nurse or obtaining a nursing assessment. CNA #1 stated she did not summon assistance or use a mechanical lift. CNA #1 stated the Director of Nursing (DON) contacted her on 08/19/26 and requested a written statement because Resident #41 had sustained a fractured leg and the facility was investigating the incident. CNA #1 stated she believed it was acceptable not to report the incident because Resident #41 denied pain. CNA #1 acknowledged the significance of the incident did not occur to her at that time.			F0600			

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F0600 SS = G	Continued from page 2 During an interview on 09/23/26 at 12:50 PM, the DON stated Resident #41 began complaining of knee pain on 08/18/26. The Nurse Practitioner (NP) was notified and assessed the resident. The DON stated Resident #41 later complained of lower-leg pain at approximately 9:30 PM. The NP was notified again, and an order was obtained for an X-ray of the resident's right leg. The DON stated the X-ray completed on 08/19/26 identified fractures of the right tibia and fibula near an area that had previously been surgically repaired. The DON stated CNA #1 should have immediately reported the fall, summoned assistance, obtained a nursing assessment, and used a mechanical lift to return Resident #41 to bed. The DON confirmed CNA #1's failure to report the fall delayed Resident #41's assessment, X-ray, and treatment by approximately one day. During an interview on 09/23/26 at 3:20 PM, the NP stated she was contacted on 08/18/26 because Resident #41 complained of significant knee pain and had received Tylenol. The NP stated Resident #41 denied pain when assessed at the bedside following rest and a nap. The NP stated she was contacted again later that day after Resident #41 developed pain and swelling of the right ankle. An X-ray was ordered and completed on 08/19/26. The X-ray identified fractures of the right tibia and fibula. The NP stated she expected staff to notify her immediately when a resident sustained a fall or injury. The NP confirmed the failure to report the fall delayed Resident #41's evaluation and treatment by approximately one day. The NP stated the delay placed Resident #41 at risk for worsening of the fractures, a compound fracture if the resident continued bearing weight, a pulmonary fat embolism, and untreated pain. During an interview on 09/24/26 at 9:30 AM, Resident #41's daughter stated the resident had a history of attempting to stand without assistance. The daughter stated Resident #41 required the assistance of one staff member for transfers before the incident and had undergone surgery involving the affected leg approximately 20 years earlier. Record review of the Radiology Interpretation dated 8/19/26 revealed "Right tibia/fibula X-ray - 2 view: Findings:...Acute oblique fracture distal tibia...Right ankle X-ray: Findings:...Acute oblique fracture distal tibia..." A record review of the "Admission Record" revealed Resident #41 had an admission date of 9/4/25 with			F0600			

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F0600 SS = G	Continued from page 3 diagnoses that included heart failure.	F0600					
F0609 SS = D	A record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 9/4/26 revealed a Brief Interview for Mental Status (BIMS) score of 15 indicating the resident was cognitively intact. Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is NOT MET as evidenced by: Based on interview, record review and facility policy review the facility staff failed to report an unwitnessed fall to the appropriate nursing staff and treatment was delayed for a fracture for one (1) of two (2) residents reviewed for accidents/reporting. Findings Include: Record review of the facility policy "Incident and Accident Reporting " revised 9/5/26 revealed "It is the policy of this facility that everything possible	F0609					

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F0609 SS = D	Continued from page 4 should be done to avoid accidents or incidents involving patients, guests, or employees of this facility. An incident report records details of an accident, injury, workplace incident, security breach, or any other type of unforeseen event..." On 09/21/26 at 2:19 PM, during an initial observation and interview, Resident #41 was seated in a wheelchair with her swollen right leg elevated on a leg rest. Resident #41 stated she had recently fallen and broken her leg and did not know what caused the fracture. On 09/23/26 at 9:41 AM, during an interview, Certified Nursing Assistant (CNA)#1 stated she worked the night shift on 08/17/26 and found Resident #41 on the floor in her room, resting on her knees on top of pillows and attempting to pull herself up by the bed. CNA #1 stated Resident #41 begged her to return her to bed and not tell anyone because of the resident's history of repeated falls. CNA #1 stated she asked Resident #41 if she was all right, and the resident denied pain. CNA #1 stated she assisted Resident #41 to stand and return to bed without reporting the incident to a nurse or obtaining a nursing assessment. CNA #1 stated she did not summon assistance or use a mechanical lift. CNA #1 stated the Director of Nursing (DON) contacted her on 08/19/26 and requested a written statement because Resident #41 had sustained a fractured leg and the facility was investigating the incident. CNA #1 stated she believed it was acceptable not to report the incident because Resident #41 denied pain. CNA #1 acknowledged the significance of the incident did not occur to her at that time. On 09/23/26 at 12:50 PM, during an interview, the DON stated CNA #1 should have immediately reported the fall, summoned assistance, obtained a nursing assessment, and used a mechanical lift to return Resident #41 to bed. The DON confirmed CNA #1's failure to report the fall delayed Resident #41's assessment, X-ray, and treatment by approximately one day. On 09/23/26 at 3:20 PM, during an interview, the NP stated she expected staff to notify her immediately when a resident sustained a fall or injury. The NP confirmed the failure to report the fall delayed Resident #41's evaluation and treatment by approximately one day. The NP stated the delay placed Resident #41 at risk for worsening of the fractures, a compound fracture if the resident continued bearing weight, a pulmonary fat embolism, and untreated pain.	F0609			

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F0609 SS = D	Continued from page 5 A record review of the "Admission Record" revealed Resident #41 had an admission date of 9/4/25 with diagnoses that included heart failure. A record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 9/4/26 revealed a Brief Interview for Mental Status (BIMS) score of 15 indicating the resident was cognitively intact.		F0609				