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| <b>STATEMENT OF DEFICIENCIES<br/>AND PLAN OF CORRECTIONS</b>                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><b>255326</b> |  | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING<br>B. WING                                             |                                                                                                                          | (X3) DATE SURVEY COMPLETED<br><b>11/19/2025</b> |                            |
| NAME OF PROVIDER OR SUPPLIER<br><b>PINE FOREST HEALTH AND REHABILITATION</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                        |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>1116 FOREST AVENUE , JACKSON, Mississippi, 39206</b> |                                                                                                                          |                                                 |                            |
| (X4) ID<br>PREFIX<br>TAG                                                     | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                        |                                                                        |  | ID<br>PREFIX<br>TAG                                                                              | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE<br>APPROPRIATE DEFICIENCY) |                                                 | (X5)<br>COMPLETION<br>DATE |
| F0000                                                                        | <b>INITIAL COMMENTS</b><br><br>On 11/19/25 the State Agency (SA) conducted a desk review of the information that was provided to our agency related to the complaint survey that was completed on 09/04/25. The information provided by the facility confirmed the facility had put measures in place to correct the deficient practice and sustain compliance with Medicare and Medicaid requirements of participation. The SA is recommending that your facility be placed back in compliance effective 10/07/25. |                                                                        |  | F0000                                                                                            |                                                                                                                          |                                                 |                            |

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.

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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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