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| <b>STATEMENT OF DEFICIENCIES<br/>AND PLAN OF CORRECTIONS</b>                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><b>255247</b> |  | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING<br>B. WING                                              |                                                                                                                          | (X3) DATE SURVEY COMPLETED<br><b>02/18/2026</b> |                            |
| NAME OF PROVIDER OR SUPPLIER<br><b>REST HAVEN HEALTH AND REHABILITATION</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                        |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>103 CUNNINGHAM DRIVE , RIPLEY, Mississippi, 38663</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                                                                       | <p>INITIAL COMMENTS</p> <p>The State Agency (SA) conducted a Complaint Investigation (CI MS #2728862) at the facility from 2/17/26 through 2/18/26. During the survey, the SA determined the facility was in compliance with the requirements of participation in Medicare and Medicaid. The SA investigated the complaint for resident abuse and misappropriation of property. There were no citations related to the complaint.</p> <p>The census at the time of the survey was 47 with a license for 60 beds.</p> |                                                                        |  | 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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