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| <b>STATEMENT OF DEFICIENCIES<br/>AND PLAN OF CORRECTIONS</b>                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><b>255141</b> |  | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING<br>B. WING                                          |                                                                                                                          | (X3) DATE SURVEY COMPLETED<br><b>08/20/2025</b> |                            |
| NAME OF PROVIDER OR SUPPLIER<br><b>PICAYUNE REHABILITATION AND HEALTHCARE CENTER</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                        |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>1620 READ ROAD , PICAYUNE, Mississippi, 39466</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 Complaint Investigations (CIs), MS #258348, MS #473145, and MS #473146, at the facility on from 8/19/25 through 8/20/25. MS #258348 was investigated for staff being rude, resident safety, and injury of unknown origin. MS # 473145 was investigated for abuse and MS #473146 was investigated for neglect and quality of care. During the survey, the SA determined the facility was in compliance with the requirements of participation in Medicare and Medicaid and there were no deficiencies cited.</p> <p>The facility held a license for 120 beds, with a census of 106.</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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