

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 04/09/2026	
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 a Complaint Investigation at the facility on 4/07/26 through 4/09/26 and investigated Complaint 2961494, Complaint 2806719, Complaint 2874513, Complaint 2968243, Complaint 2966163, and Complaint 2964901. Complaint 2961494 was investigated related to resident rights; Complaint 2806719 was investigated related to resident rights, Complaint 2874513 was investigated related to quality of care, Complaint 2968243 was investigated related to death in facility and neglect, Complaint 2966163 was investigated related to infection control and quality of care, and Complaint 2964901 was investigated related to quality of care, neglect, nursing services, administration, call lights no working/not answered in a timely manner, resident rights, and accidents/elopement. During the survey, the SA determined the facility was in compliance with the requirements for participation in Medicare and Medicaid and there were no deficiencies cited. The facility held a license for 120 beds, with a census of 109 residents.		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.

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