STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255319	A. BUILDING _____ B. WING _____	03/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNSHINE HEALTH CARE, INC	1677 HIGHWAY 9 NORTH PONTOTOC, MS 38863

(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
F 000	INITIAL COMMENTS The State Agency (SA) conducted an annual re-certification survey at the facility from 3/4/2024-3/6/2024. During the survey, the SA determined the facility was not in compliance with Medicare and Medicaid requirements of participation. The SA identified non-compliance and cited F641 for failure to correctly code a resident discharge Minimum Data Set Assessment. The census at the time of the survey was 56 and the facility is licensed for 60 beds.	F 000		
F 641 SS=B	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to accurately code the Minimum Data Set (MDS) assessment for discharge for one (1) of 17 resident assessments reviewed. Resident #56. Findings include: Record review of Resident #56's Discharge assessment-return not anticipated MDS with an Assessment Reference Date (ARD) of 12/16/23, revealed Resident # 56 was discharged to an acute care hospital. During an interview with the Director of Nursing (DON) on 3/6/24 at 10:00 AM, she stated Resident #56 was not hospitalized.	F 641	Statements contained herein are intended for the purpose of compliance with Federal and State laws regarding responses to Statement of Deficiencies. The language herein is not intended to be used as an admission against the facility nor is it intended to be used by any third party. It is solely for the purpose of compliance with participation requirements of Medicare and Medicaid. Tag 0641-483.20(g) Corrective Action: On 03/06/2024 the Minimum Data Sets (MDS) Licensed Practical Nurse (LPN)	4/9/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		03/14/2024

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 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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255319	A. BUILDING _____ B. WING _____	03/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNSHINE HEALTH CARE, INC	1677 HIGHWAY 9 NORTH PONTOTOC, MS 38863

(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
F 641	Continued From page 1 In an interview with MDS Licensed Practical Nurse (LPN) and the MDS Coordinator on 3/6/24 at 10:10 AM, she verified that Resident #56 discharged home not to the hospital. MDS LPN revealed that she was the one who coded the MDS and that it was coded incorrectly and stated it was a data entry error. MDS Coordinator verified that the MDS was coded incorrectly and revealed that it was her expectation that the MDS would be coded correctly. They both agreed the importance of correctly coding the MDS accurately is to identify where the resident is located. Record review of Resident # 56's Face Sheet revealed that the facility admitted her on 9/8/23 with a diagnosis of Femur fracture.	F 641	corrected the Minimum Data Sets (MDS) for Resident 56 "Discharge Assessment" to reflect that resident discharged home. On 03/06/2024 a One-On-One in-service was conducted by the Director of Nursing of the facility with the Minimum Data Sets (MDS) Registered Nurse (RN) Coordinator and Minimum Data Sets (MDS) Licensed Practical Nurse (LPN) regarding correct coding of discharge assessments. As any and all residents have the potential to be affected, an audit of 14 discharged residents, which represents 1/4 of the facility's census was conducted on March 07, 2024 with no discharge coding errors found. On 03/06/2024, the facility's Policy and Procedures related to Minimum Data Set coding was reviewed by the Administrator, Director of Nursing, Quality Assurance Coordinator, Minimum Data Sets (MDS) Registered Nurse (RN) Coordinator and Minimum Data Sets (MDS) Licensed Practical Nurse (LPN) and no recommended changes were given. Starting on March 08,2024, the facility's Minimum Data Sets (MDS) Registered Nurse (RN) Coordinator will conduct audits of the Minimum Data Sets (MDS) Licensed Practical Nurse (LPN) coding of each discharged resident and report findings to the Quality Assurance Performance Improvement (QAPI) Committee on March 19, 2024 and April	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255319	A. BUILDING _____ B. WING _____	03/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNSHINE HEALTH CARE, INC	1677 HIGHWAY 9 NORTH PONTOTOC, MS 38863

(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
F 641	Continued From page 2	F 641	09, 2024 and monthly for a total of six months (March 2024 - August, 2024). Any errors noted shall be corrected immediately.	