STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255244	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNPLEX SUB-ACUTE CENTER	**6520 SUNSCOPE DRIVE , OCEAN SPRINGS, Mississippi, 39564**

(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 Complaint Investigations (CIs), MS #2614899, CI MS #2622122, Incident #2621333, and CI MS #2625388, at the facility from 9/22/25 through 9/24/25. MS #2614899 was investigated for failure to provide timely assistance with activities of daily living, concerns regarding professional conduct of staff, neglect, delay in hygiene and toileting care, and medication administration concerns following a resident's return from the hospital. CI MS #2622122 was investigated for lack of elopement assessments, failure to supervise a resident with exit-seeking behavior, short staffing, falsification of documentation, and inadequate Certified Nursing Assistant (CNA) training for residents at risk for elopement. CI MS #2621333, a facility reported incident (FRI), was investigated related to resident elopement. MS #2625388 was investigated for staffing concerns, failure to meet residents' care needs due to insufficient numbers of aides, and reports of facility administration instructing staff not to communicate with surveyors. There were no citations related to the investigations for CI MS #2614899 and CI MS #2625388. During the survey and CIs related to CI MS #2622122 and CI MS #2621333, the SA determined the facility was in compliance with the requirements for participation in Medicare and Medicaid. The facility failed to provide supervision to prevent Resident #1, who was identified as a risk for wandering and elopement, from leaving the facility without supervision. The facility's failure to provide adequate supervision and implement effective interventions to prevent an elopement for Resident #1 who was identified by the facility as an elopement risk and had severe cognitive impairment, exited the facility on 9/17/25, at approximately 8:30 PM. Resident #1 was assisted out of the front door by a Dietary Aide (DA) who thought she was a visitor. She remained outside the facility for approximately 35 minutes, during which the DA left the facility parking lot at approximately 8:50 PM. Resident #1 was found at 9:05 PM knocking on the front entrance door. During the investigation of the FRI, the SA identified	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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255244	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNPLEX SUB-ACUTE CENTER	6520 SUNSCOPE DRIVE , OCEAN SPRINGS, Mississippi, 39564

(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	Continued from page 1 an Immediate Jeopardy (IJ) and Substandard Quality of Care (SQC) that began on 9/17/25 and existed at: 42 CFR 483.25(d)(1)(2) – Free of Accidents Hazards/Supervision/Devices (F689) – Scope and Severity "J" This situation placed Resident #1 and other residents at risk for wandering and elopement, at risk for serious injury, serious harm, serious impairment, or death. The SA notified the facility's Administrator of the IJ and SQC on 9/23/25 at 2:00 PM and provided the Administrator with the IJ Template. Based on the facility's implementation of corrective actions completed on 9/18/25, the SA determined the IJ and SQC to be Past Non-Compliance (PNC) and the IJ was removed on 9/19/25, prior to the SA's entrance on 9/22/25. At the time of the survey, the facility was licensed for 73 beds, with a census of 58 residents.	F0000		
F0689 SS = SQC-J	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interviews, record review, and facility policy review, the facility failed to provide adequate supervision to prevent an elopement for one (1) of four (4) sampled residents, Resident #1. On 9/17/25, Resident #1, who had a Brief Interview for Mental Status (BIMS) score of six (6), and was identified by the facility as an elopement risk, was assisted out of the front door by a Dietary Aide (DA) who thought she was a visitor. She remained outside the facility for approximately 35 minutes, during which the	F0689	"Past Noncompliance - no plan of correction required"	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255244	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNPLEX SUB-ACUTE CENTER	6520 SUNSCOPE DRIVE , OCEAN SPRINGS, Mississippi, 39564

(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
F0689 SS = SQC-J	Continued from page 2 DA left the facility parking lot at approximately 8:50 PM. Resident #1 was found at 9:05 PM knocking on the front entrance door. The facility's failure to provide supervision placed Resident #1 and other vulnerable residents at risk for serious injury, serious harm, serious impairment, or death. The situation was determined to be an Immediate Jeopardy (IJ) and Substandard Quality of Care (SQC), which began on 9/17/25, when Resident #1 exited the facility. The State Agency (SA) notified the Administrator of the IJ on 9/23/25 at 2:00 PM and provided an IJ Template. Based on the facility's implementation of corrective actions on 9/18/25, the SA determined the IJ and SQC to be Past Non-Compliance (PNC) and the IJ was removed as of 9/19/25 prior to the SA's entrance on 9/22/25. Findings include: A review of the facility's policy, Elopement/Unsafe Wandering Plan," dated February 7, 2012, revealed, "…It is the policy of this facility to protect the resident from harm while providing care in a manner that helps promote quality of life in a safe environment…Definitions…3. Elopement-Elopement occurs when a resident leaves the premises or a safe area without authorization…" A record review of the facility's investigation revealed on 9/17/2025, at 9:00 PM, Certified Nurse Assistant (CNA) #1, identified that Resident #1 was not in the common area or in her room when she returned from her lunch break. The Registered Nurse/Minimum Data Nurse (RN/MDS) was in the facility and was notified that Resident #1 was not on her side of the building. The RN/MDS nurse immediately called a Code W (elopement) and initiated a search of the building and perimeter. CNA #2 found Resident #1 who was knocking on the front door at 9:05 PM while searching in her assigned area; Resident #1 was dressed appropriately for the weather and had her purse on her shoulder. Resident #1 was escorted back into the building with no issues of distress noted. The Administrator and the Director of Nurses (DON) were notified of the incident. The RN/MDS completed a body audit with no signs or symptoms of injury. The RN/MDS completed a head count of all current residents in the facility, and all residents were accounted for. She also notified the medical provider and Resident Representative (RR). The Administrator arrived at the facility and checked that	F0689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255244	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNPLEX SUB-ACUTE CENTER	6520 SUNSCOPE DRIVE , OCEAN SPRINGS, Mississippi, 39564

(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
F0689 SS = SQC-J	Continued from page 3 all doors were functioning properly. The root cause analysis determined by the Administrator and DON found that Resident #1 followed a dietary employee while he was leaving at the end of his shift. It was determined through interviews that the dietary employee was unaware that Resident #1, was a resident and was under the impression that she was a visitor. A record review of the "Admission Record" revealed the facility admitted Resident #1 on 9/16/25 with current diagnoses including Wernicke's encephalopathy and vascular dementia. A record review of the "BIMS (Brief Interview for Mental Status) Interview MDS", dated 9/16/25, revealed Resident #1 had a BIMS score of 6, which indicated her cognition was severely impaired. A record review of the local weather report revealed on 9/17/25 from 7:55 PM to 8:55 PM, the temperature was 83 degrees and clear. On 9/22/25 at 8:30 PM, during an observation of the facility and surrounding area, the facility is located approximately 925 feet from a four-lane highway and is situated within an industrial complex with multiple surrounding commercial buildings. A wooded area borders the south side of the property. The facility grounds include a paved parking lot with designated spaces for staff and visitors, and sidewalks providing access to the front entrance. Multiple exterior lights were observed around the building perimeter, including at the front entrance and doorways. There are no fencing or restricted barriers observed between the facility grounds and the surrounding industrial area. On 9/22/25 at 9:15 PM, during an interview with CNA #1, she confirmed that she was assigned to Resident #1 on 9/17/25. She reported that she last observed the resident sitting in the main lobby prior to leaving for her scheduled lunch break at approximately 8:30 PM. CNA #1 stated that when she returned from break around 9:00 PM, Resident #1 was not in her room or in the lobby. She immediately notified the RN/MDS nurse and other staff that the resident was missing, and a facility-wide search was initiated. At approximately 9:05 PM, CNA #2 located Resident #1 knocking on the facility's front door. CNA #1 confirmed that she was aware the resident was care-planned as an elopement risk, with 15-minute checks in place and identification in the wander book. She stated the facility followed its elopement policy, secured exits, and ensured all residents were accounted for. She further reported that after the incident, she was included in an in-service	F0689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255244	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNPLEX SUB-ACUTE CENTER	6520 SUNSCOPE DRIVE , OCEAN SPRINGS, Mississippi, 39564

(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
F0689 SS = SQC-J	Continued from page 4 on elopement prevention and policies. On 9/22/25 at 9:25 PM, during an interview with CNA #2, she stated that on 9/17/25 while working on her unit, staff realized Resident #1 was not accounted for. CNA #2 explained that at approximately 9:00 PM, CNA #1 asked if she had seen Resident #1. When she confirmed she had not, the facility immediately implemented its elopement policy and all staff began searching the building and grounds. CNA #2 reported that she was aware Resident #1 was identified as an elopement risk in the wander book and wore a yellow bracelet. She began her search in the main lobby and near the front entrance of the facility. While checking that area at approximately 9:05 PM, she heard knocking at the front door. Upon opening the door, she identified Resident #1 outside the facility. She confirmed that the resident was appropriately dressed for the weather, carrying her purse, did not appear injured or distressed, and was safely escorted back inside. CNA #2 revealed that following the event, she observed the RN/MDS nurse complete a body audit and headcount of all residents. She further reported that she later participated in a staff in-service regarding the facility's elopement policy and procedures. On 9/23/25 at 11:20 AM, during an interview with Dietary Aide #1, he revealed that on 9/17/25, after completing his dietary shift, he clocked out and went to leave the building. He explained that he did not know the exit code, so he went to a nurses' station to obtain it. After entering the code at the front door, he exited the facility. At that time, an individual followed closely behind him and opened the door as he exited. Dietary Aide #1 reported that he did not recognize the person as a resident, as she was dressed in street clothes appropriate for the weather and was carrying a purse. He assumed she was a visitor leaving at the same time. The employee revealed that once he entered his father's car, both he and his father observed the woman attempt to get into a parked vehicle in the lot. When she discovered the car was locked, she returned to the facility's front entrance. He confirmed that later he learned that the individual was Resident #1. He stated he had previously received annual training on elopement prevention and resident identification but admitted he did not initially recognize Resident #1 as a resident due to her appearance and belongings. Following the incident, the employee confirmed he received re-education on the elopement policy, door security procedures, and how to identify and respond if a resident attempts to exit with staff or visitors.	F0689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255244	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNPLEX SUB-ACUTE CENTER	6520 SUNSCOPE DRIVE , OCEAN SPRINGS, Mississippi, 39564

(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
F0689 SS = SQC-J	Continued from page 5 A record review of the “Employee Time Cards” revealed on 9/17/25 Dietary Employee #1 clocked out of the facility at 8:27 PM. On 9/23/25 at 1:32 PM, during an interview, the RN/MDS confirmed that on 9/17/25, at approximately 9:00 PM, she was informed that Resident #1 was missing from her unit. She immediately called a Code W (elopement). All staff secured the doors, conducted a head count of all residents, and began a facility-wide search. At approximately 9:05 PM, Resident #1 was located at the front door, knocking to be let back inside. The RN/MDS stated that following the event, she notified the Administrator and Director of Nursing (DON). Once all residents were accounted for, the resident’s physician and RR were also notified. Resident #1 was assessed and had no injuries. She was observed to be dressed in a gray short-sleeved shirt, brown shorts, and sandals, with her purse on her shoulder and sunglasses on top of her head. The RN/MDS further explained that Resident #1 had previously been assessed as an elopement risk, and her name and information had been placed in the elopement books located at each nurses’ station, the kitchen, and therapy department. She also wore a yellow elopement-risk bracelet. Following the incident, the resident’s care plan was updated with new interventions. On 9/23/25 at 1:50 PM, during an interview with the Administrator, she confirmed that on 9/17/25 at approximately 9:00 PM, staff identified that Resident #1 was missing, and the MDS nurse immediately initiated a Code W (elopement). Staff secured all doors, conducted a head count, and began searching the building and perimeter. At approximately 9:05 PM, the resident was found knocking at the front door, appropriately dressed and without distress. A body audit revealed no injuries, and the medical provider and responsible representative were notified. The Administrator stated she verified the doors were functioning, interviewed involved staff and residents, and initiated in-services for all employees on elopement procedures before their next shift. The incident was reported to State Agency (SA) and the Attorney General’s office, and an emergency Quality Assurance Performance Improvement (QAPI) meeting was held to implement corrective actions. These included door quality checks, alarms on exits, elopement drills on all shifts, wander assessments on all residents, and audits of care plans and elopement books. She further explained that the root cause analysis determined the resident had followed Dietary Aide#1 out of the building, as the employee mistakenly assumed the resident was a visitor.	F0689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255244	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNPLEX SUB-ACUTE CENTER	6520 SUNSCOPE DRIVE , OCEAN SPRINGS, Mississippi, 39564

(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
F0689 SS = SQC-J	Continued from page 6 On 9/23/25 at 1:50 PM, during an interview, the Director of Nursing (DON) confirmed that on 9/17/25 she was notified by the Administrator and RN/MDS that Resident #1 had been found outside the facility, knocking on the front door. The DON stated that the RN/MDS verified all residents were accounted for and notified the resident's physician and RR. Resident #1 was assessed with no injuries noted and was observed to be appropriately dressed in a gray short-sleeve shirt, brown shorts, sandals, with her purse on her shoulder and sunglasses on top of her head. The DON further confirmed that Resident #1 had previously been assessed as an elopement risk, with her name and information placed in the elopement books located at each nurses' station, the kitchen, and therapy department. The resident also wore a yellow elopement-risk bracelet. Following the incident, the resident's care plan was updated with additional interventions. The facility submitted a corrective action plan as follows: 9/17/25 at 9:00 PM, CNA#1 noted that Resident #1 was not in the common area or in her room when CNA #1 returned from her lunch break. CNA #1 reported to MDS Nurse #1 that Resident#1 was not in the common area or in her room. MDS Nurse called Code W (elopement), and all staff began a search of the facility and perimeter. 9/17 /25 at 9:05 PM, CNA#2 was searching in the front of the building where the conference room and business office are located and heard Resident #1 knocking on the front door. Resident#1 was brought in with no signs of distress, only stating she was lost. Resident#1 was clothed appropriately with her purse on her shoulder. The weather was clear skies and around 75 degrees. 9/17/25 at 9:10 PM, Administrator was notified by MDS Nurse about the incident. The Administrator notified the Director of Nursing (DON) of incident. 9/17/25 at 9:18 PM, MDS Nurse completed body audit with no signs or symptoms of injury. 9/17125 at 9:30 PM, MDS Nurse completed a head count of all current residents in the facility, and all residents were accounted for. 9/17 /25 at 9:40 PM, MDS Nurse notified Resident #1 's representative of the incident. 9/17/25 at9:45 PM, Medical Director (MD) was notified of Resident#1's incident and no new orders were given.	F0689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255244	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNPLEX SUB-ACUTE CENTER	6520 SUNSCOPE DRIVE , OCEAN SPRINGS, Mississippi, 39564

(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
F0689 SS = SQC-J	Continued from page 7 9/17/25 at 10:15 PM, the Administrator arrived at the facility and checked that all doors were functioning properly. The Administrator interviewed all employees and any residents that had interactions with Resident #1 prior to the incident. 9/17/25 at 10:30 PM, Administrator began in-service for all employees on elopement policy and procedures. All staff would be in-serviced before returning to their next shift. 9/17/25 at 10:46 PM, Administrator reported incident to State Agency. 9/18/25 at 9:00 AM, an emergency Quality Assurance & Performance Improvement (QAPI) committee meeting was held to discuss incident, actions taken, and further interventions. 9/18/25 at 9:15 AM, Social Services Director spoke with Resident #1 and noted no psychosocial harm due to incident. 9/18/25 at 10:30 AM, Maintenance Director conducted a quality check of all doors to make sure they were operating as expected and door alarms were added to all of the doors. 9/18/25 at 11:00 AM, Regional Director of Operations interviewed Resident#1 and Resident #2 for any details they remember about the incident. 9/18/25 at 12:25 PM, during education of elopement policy and procedures with dietary staff, Dietary Aide #1 stated that Resident #1 had followed him out of the building on 9/17/25. Dietary Aide #1 clocked out at 8:27 PM and went to the front door to exit. Dietary Aide #1 did not know the new front door code and went to nurse's station to get code. When Dietary Aide #1 came back through the facility, the resident followed him to the front door and went out behind him after 8:30 PM. Dietary Aide #1 stated that he sat in the parking lot until 8:50 PM with eyes on Resident #1 trying to determine if Resident #1 was a visitor. 9/18/25 at 2:00 PM, wander assessments were completed on all active residents in the facility by DON, Registered Nurse (RN) #1, Licensed Practical Nurse (LPN) #1, and Medical Records LPN. One out of sixty-one residents was identified at risk for elopement. 9/18/25 at 2:00 PM, Maintenance Director began elopement drills for all shifts and completed on	F0689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255244	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNPLEX SUB-ACUTE CENTER	6520 SUNSCOPE DRIVE , OCEAN SPRINGS, Mississippi, 39564

(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
F0689 SS = SQC-J	Continued from page 8 9/19/2025 at 5:30 AM. 9/18/25 at 3:30 PM, a follow up QAPI committee meeting was held by Administrator to discuss that all interventions were in place. These interventions are as follows: Maintenance will conduct a quality check of all doors, an elopement drill on each shift within the next 24 hours and put alarms on each of the doors. Completed on 9/18/2025 at 2:00 PM: Administrative nurses completed wander assessments on all current residents, update care plans and wander books accordingly; completed a 100 percent audit of care plans; completed 100 percent audit of wander books located at both nurse's stations. Social services would interview Resident #1 for any psychosocial harm. Administrative staff would in-service all employees on elopement policy and procedures before their next shift. The root cause analysis determined by Administrator and DON found that the resident followed out a dietary employee while he was leaving at the end of his shift. It was determined through interviews with Dietary Aide #1 that he was unaware that Resident #1 was a resident, under the impression that she was a visitor. The QAPI committee meeting determined at this time to prevent further adverse events the interventions would include elopement drills on all shifts and one elopement drill per week for four weeks on alternating shifts and one per month for six months on alternating shifts. Person-centered in-services will be completed with all staff for any new residents identified as an elopement risk or any current residents who are newly identified as an elopement risk. 9/22/25 at 4:40 PM, incident was reported to Attorney General's office by Administrator. Facility alleges that all corrective actions were complete on 9/18/2025 and Immediate Jeopardy removed on 9/19/2025. Validation: The SA validated through interview and record review view, that all corrective actions had been implemented as of 9/18/25, and the facility was in compliance as of 9/19/25, prior to the SA’s entrance on 9/22/25.	F0689		