STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255319	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNSHINE HEALTH CARE, INC	1677 HIGHWAY 9 NORTH , PONTOTOC, Mississippi, 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
F0000	INITIAL COMMENTS The State Agency (SA) conducted an annual re-certification survey at the facility from 7/21/25 through 7/24/25. During the survey, the SA determined that the facility was not in compliance with the requirements for participation in Medicare and Medicaid and cited F 641 for failure to accurately code Minimum Data Set Assessments. The census at the time of the survey was 55 and the facility is licensed for 60 beds.	F0000		08/11/2025
F0641 SS = D	Accuracy of Assessments CFR(s): 483.20(g)(h)(i)(j) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. §483.20(h) Coordination. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. §483.20(i) Certification. §483.20(i)(1) A registered nurse must sign and certify that the assessment is completed. §483.20(i)(2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. §483.20(j) Penalty for Falsification. §483.20(j)(1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or	F0641	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: F641 Corrective Action: On 07/23/2025 The Minimum Data Sets (MDS) Registered Nurse (RN), corrected the Minimum Data Sets (MDS) for residents #1, #3, #7, #21, #33 to properly identify the use of anti-platelet medications. On 07/23/2025 The Minimum Data Sets (MDS) Registered Nurse (RN), corrected the Minimum Data Sets (MDS) for residents #10 to properly reflect that the Level 2 PASRR had been completed and that the resident is receiving the correct level of care. 07/23/2025 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 anti-platelet medications. A list of commonly used anti-platelet and anticoagulant	08/29/2025

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

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F0641 SS = D	Continued from page 1 (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. §483.20(j)(2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is NOT MET as evidenced by: Based on record review, staff interview and facility policy review the facility failed to ensure that the Minimum Data Set (MDS) assessment was coded accurately for a serious mental illness (Resident #10) and for the use of anticoagulant medications (Resident # 1, #3, #7, #21 and #33) for six (6) of 32 sampled residents. Findings include: Record review of the facility policy titled, "Resident Assessment Instrument (RAI) Policy" with no revision date revealed, "It is the policy of this facility that the RAI will be done as follows: According to the guidelines specified by CMS (Centers for Medicare and Medicaid Services)." Resident #1 Record review of "Order Summary Report" during initial pool revealed Resident #1 was not on an anticoagulant medication but was on Plavix, an antiplatelet medication. The resident was coded on the MDS assessment as being on anticoagulant and antiplatelet medication. Record review of Resident #1's "Order Summary Report" revealed an order dated 4/4/25 for Plavix 75 milligrams (mg) by mouth one time a day for Peripheral Vascular Disease. Review revealed there was no order for an anticoagulant medication. Record review of Resident #1's Minimum Data Set (MDS) Section N dated 7/7/25 revealed the resident was coded for receiving an anticoagulant. Record review of the "Admission Record" revealed Resident #1 was admitted to the facility on 12/23/24 and diagnoses included Unspecified Atrial Fibrillation and Peripheral Vascular Disease. Resident #3 A record review of Resident #3's “Order Summary Report” with active orders as of 7/23/25 revealed an order	F0641	Continued from page 1 medications was provided for ready reference in composing facility's resident Minimum Data Sets (MDS) information. (See Attachments #1 and #2) 07/23/2025 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 proper coding of the Minimum Data Sets (MDS) to reflect that the Level 2 PASRR is coded correctly in-order to insure the resident is receiving the correct level of care. (See Attachments #1 and #3) As any and all residents have the potential to be affected, on 07/23/2025 an audit was conducted by the facility's Director of Nursing, Assistant Director of Nursing, the Health Information Manager Nurse and the Minimum Data Sets (MDS) Registered Nurse (RN), of all current residents charts, with no further coding errors found related to anti-platelet use, (See Attachment #4.) As any and all residents have the potential to be affected, on 08/05/2025 an audit was conducted by the facility's Director of Nursing, Assistant Director of Nursing and the Social Services Director, of all resident MDS charts of Section A1500 related to their Level 2 PASRR determinations. A total of three (3) residents coding on Section A1500 were found to be mis-coded. The Minimum Data Sets (MDS) Registered Nurse (RN) and Minimum Data Sets (MDS) nurse (LPN) was provided with this information and they in-turn corrected the errors. (See Attachment # 5.) On 07/23/2025 the facility's Policy and Procedures related to the Minimum Data Sets (MDS) coding was reviewed by the facility's Administrator, Director of Nursing, Quality Assurance Coordinator, Minimum Data Sets (MDS) Registered Nurse (RN) Coordinator, and Minimum Data Sets (MDS) Licensed Practical Nurse (LPN) with no recommended changes given. Beginning of 08/01/2025 the facility's Director of Nursing, Assistant Director of Nursing, Quality Assurance Nurse, Minimum Data Sets (MDS) Registered Nurse (RN) Coordinator and the Minimum Data Sets (MDS) Licensed Practical Nurse (LPN), implemented an audit process by which current Minimum Data Sets (MDS) were audited for accuracy of anti-platelet medications prior to submission. Any errors will be corrected	

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F0641 SS = D	Continued from page 2 dated 6/26/25 for Plavix 75 mg by mouth one time per day. There were no orders identified for an anticoagulant. A record review of Resident #3's MDS with an ARD of 7/03/25 under section N, revealed that Resident #3 was coded as being on an anticoagulant. A record review of the "Admission Record" revealed Resident #3 was admitted by the facility on 6/26/25 with a diagnosis of Metabolic Encephalopathy. Resident #7 Record review of MDS Section N dated 6/9/25 revealed Resident #7 was coded as receiving an anticoagulant medication. Record review of Resident #7's "Order Summary Report" revealed an order dated 1/2/24 for Clopidogrel (Plavix) 75 mg by mouth daily for Peripheral Vascular Disease. Review revealed there was no order for an anticoagulant medication. Record review of Resident #7's "Admission Record" revealed she was admitted to the facility on 1/11/22. Diagnoses included Stage 3 Chronic Kidney Disease and Peripheral Vascular Disease. Resident #21 A record review of the “Order Summary Report” dated 07/23/25, revealed an order for Plavix 75 mg by mouth one time per day. There were no orders identified for an anticoagulant. A record review of MDS with an ARD of 04/23/25 under section N, revealed that Resident #21 was on an anticoagulant. A record review of the "Admission Record" revealed Resident #21 was admitted by the facility on 10/08/24 with a diagnosis of Diabetes Mellitus. Resident #33 A record review of the MDS with an ARD of 04/24/25 under section N, revealed that Resident #33 was on an anticoagulant. A record review of “Order Summary Report” dated 07/23/25, revealed an order for Plavix 75 mg by mouth one time per day. There were no orders identified for an anticoagulant.	F0641	Continued from page 2 immediately. This new audit process will continue weekly, times six (6) weeks, then monthly times three (3), then quarterly times four (4), then random audits will be conducted by the Quality Assurance Registered Nurse (RN) or designate. Findings will be reported to the QAPI Committee meeting on 082725 and to the Quality Assurance Committee at its quarterly meetings, September 2025, December 2025 and each quarter thereafter through December 2026. (See Attachment # 6.) Beginning of 08/01/2025 the facility's Director of Nursing, Assistant Director of Nursing, Quality Assurance Nurse, Social Service Coordinator, Minimum Data Sets (MDS) Registered Nurse (RN) Coordinator and the Minimum Data Sets (MDS) Licensed Practical Nurse (LPN), implemented an audit process by which current Minimum Data Sets (MDS) were audited for accuracy of the PASRR prior to submission. Any errors will be corrected immediately. This new audit process will continue weekly, times six (6), then monthly, times three (3), then quarterly, times four (4), then random audits will be conducted by the Quality Assurance Registered Nurse (RN) or designate. Findings will be reported to the QAPI Committee meeting on 082725 and to the Quality Assurance Committee at its quarterly meetings, September 2025, December 2025 and each quarter thereafter through December 2026. (See Attachments # 6 and # 7.)	

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F0641 SS = D	Continued from page 3 A record review of the "Admission Record" revealed Resident #33 was admitted by the facility on 01/20/25 with a diagnosis of Metabolic Encephalopathy. During an interview with the Registered Nurse (RN) MDS Coordinator on 7/22/25 at 1:30 PM, she revealed that Resident #1, #3, #7, #21 and #33 were on Plavix (Clopidogrel) and aspirin, and she coded Plavix as an anticoagulant and aspirin as an antiplatelet. She stated she was unaware that Plavix was an antiplatelet and not an anticoagulant medication and confirmed she should have coded this as an antiplatelet. She confirmed the MDS represents the care and condition of the resident and should be coded accurately, and she failed to do this when an antiplatelet was coded inaccurately as an anticoagulant. During an interview on 7/22/25 at 2:20 PM, the Director of Nursing (DON) confirmed that Plavix was an antiplatelet, not an anticoagulant medication. She stated her expectation was for the MDS, which represents the condition of the residents, to be accurately completed. She confirmed the facility failed to accurately complete the MDS assessment for these residents. Resident #10 Record review of Resident # 10's Significant Change MDS with an ARD of 1/9/25, revealed Section A 1500 coded as "No", Is the resident currently considered by the state level II PASRR (Preadmission Screening and Resident Review) process to have serious mental illness and/or intellectual disability or a related condition?" Record review of Resident # 10's "Summary of Findings Report", from the PASRR Office, dated 8/18/23, under "Mental Health" revealed "the individual meets criteria for having a diagnosis of mental illness as defined by PASRR." During an interview with the MDS Coordinator on 7/22/25 at 2:45 PM, she verified that the Significant Change MDS with an ARD of 1/9/25, for Resident # 10 was coded incorrectly. She agreed that the MDS should be coded correctly to ensure that the resident is receiving the correct level of care. In an interview with the Director of Nursing (DON), on 7/22/25 at 3:00 PM she agreed that it was her expectation that the MDS would be coded correctly. A record review of the "Admission Record" revealed	F0641		

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F0641 SS = D	Continued from page 4 Resident #10 was admitted by the facility on 5/19/22 with diagnoses of Schizoaffective Disorder and Major Depressive Disorder.	F0641		