

Mississippi State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/24/2025	
NAME OF PROVIDER OR SUPPLIER SUNSHINE HEALTH CARE, INC				STREET ADDRESS, CITY, STATE, ZIP CODE 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
M0000	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 compliant with the requirements of the Mississippi Regulations for Minimum Standards for Institutions for Aged or Infirm. The census at the time of the survey was 55 and the facility is licensed for 60 beds.			M0000			08/11/2025

Office of Primary Care and Health Systems Management

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