

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 09/02/2025	
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 On 07/2425 the State Agency (SA) conducted a licensure survey and determined your facility was in compliance with the Minimum Standards of Operation for Institutions for the Aged or Infirm.		M0000				

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