

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/29/2021  
FORM APPROVED  
OMB NO. 0938-0391

|                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                            |  |                                                                                                       |                                                                                                                          |                                                                        |                            |
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| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>255244</b> |  | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____                                  |                                                                                                                          | (X3) DATE SURVEY<br>COMPLETED<br><br><b>C</b><br><br><b>02/19/2021</b> |                            |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>SUNPLEX SUB-ACUTE CENTER</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                            |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>6520 SUNSCOPE DRIVE</b><br><b>OCEAN SPRINGS, MS 39564</b> |                                                                                                                          |                                                                        |                            |
| (X4) ID<br>PREFIX<br>TAG                                            | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                            |  | ID<br>PREFIX<br>TAG                                                                                   | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |                                                                        | (X5)<br>COMPLETION<br>DATE |
| F 000                                                               | <p><b>INITIAL COMMENTS</b></p> <p>The State Survey Agency (SA) conducted a complaint investigation (CI MS #17300, CI MS #17512, CI MS #17491) on 2/19/2021. The result of the investigation was unsubstantiated with no deficiencies cited. The SA determined the facility was in compliance with Medicare and Medicaid requirements for participation.</p> <p>CI MS #17300<br/>The result of the investigation was unsubstantiated with no deficiencies cited for Quality of Care related to Physician Not Notified of Resident Change and Pharmaceutical Services. The SA determined the facility was in compliance with Medicare and Medicaid requirements for participation.</p> <p>CI MS #17491<br/>The result of the investigation was unsubstantiated with no deficiencies cited for Quality of Care related to Call Bell Not Answered Timely, Inappropriate Feeding Assistance, Resident Left Wet for Extended Periods, Improper Incontinent Care for Resident, Improper Infection Control Practice, and Resident Not Groomed Adequately, Neglect related to Assess and Physical Environment related to Facility Not Clean. The SA determined the facility was in compliance with Medicare and Medicaid requirements for participation.</p> <p>CI MS #17512<br/>The result of the investigation was unsubstantiated with no deficiencies cited for Quality of Care related to Client Services Not Performed Per Physicians Order, Resident Not Groomed Adequately, Facility Staffing,</p> |                                                                            |  | F 000                                                                                                 |                                                                                                                          |                                                                        |                            |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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.

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| F 000                                                               | Continued From page 1<br>Responsible Party Not Notified of Resident<br>Change and Neglect related to Pressure Sore<br>and Assess. The SA determined the facility was in<br>compliance with Medicare and Medicaid<br>requirements for participation. | F 000                                                                      |                                                                                                                          |                            |                                                                    |