STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255244	A. BUILDING _____ B. WING _____	C 02/19/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNPLEX SUB-ACUTE CENTER	**6520 SUNSCOPE DRIVE OCEAN SPRINGS, MS 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
F 000	INITIAL COMMENTS 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. CI MS #17300 The result of the investigation was unsubstantiated with no deficiencies cited for Quality of Care related to Physician Not Notified of Resident Change and Pharmaeutical Services. The SA determined the facility was in compliance with Medicare and Medicaid requirements for participation. CI MS #17491 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. CI MS #17512 The result of the investigation was unsubstantiated with no deficiencies cited for Quality of Care related to Client Services Not Perfomed Per Physicians Order, Resident Not Groomed Adequately, Facility Staffing,	F 000		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 000	Continued From page 1 Responsible Party Not Notified of Resident Change and Neglect related to Pressure Sore and Assess. The SA determined the facility was in compliance with Medicare and Medicaid requirements for participation.	F 000		