

MSDH - Health Facilities Licensure and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 58SR	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 11/03/2022
NAME OF PROVIDER OR SUPPLIER SUNSHINE HEALTH CARE, INC		STREET ADDRESS, CITY, STATE, ZIP CODE 1677 HIGHWAY 9 NORTH PONTOTOC, MS 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) COMPLETE DATE
M 000	Initial Comments The State Agency (SA) conducted an annual recertification survey and complaint investigation, CI MS# 19491, at the facility from 11/1/22 through 11/3/22. During the survey, the SA determined the facility was in compliance with the Minimum Standards of Operation for Institutions for the Aged or Infirm and and cited no deficiencies. The census at the time of the survey was 50 with a bed capacity of 60.	M 000		

Mississippi State Department of Health

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

TITLE

(X6) DATE

Electronically Signed

11/14/22