MSDH - Health Facilities Licensure and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	58SR	A. BUILDING: _____ B. WING _____	C 04/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNSHINE HEALTH CARE, INC	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 Initial Comments: CI MS #21199 On 04/17/23 - 04/19/23 the State Agency (SA) conducted an on site complaint investigation, CI MS #21199 that alleged the cognitively impaired residents were not appropriately supervised during tranport to outside appointments and that the facility was not providing the residents with the necessary services for tranportation. The SA determined that the facility was in substantial compliance with the requirements and regulations for the Aged and Infirmed and no deficiencies were cited. The facility was licensed for 60 beds on 04/17/23 -04/19/23 and the resident census was 54.	M 000		

Mississippi State Department of Health

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

Electronically Signed | 05/04/23