

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255319		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 06/25/2026	
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
F0000	INITIAL COMMENTS The State Agency (SA) conducted an annual re-certification survey at the facility from 6/22/26 through 6/25/26. During the survey, the SA determined the facility was not in compliance with Medicare and Medicaid requirements of participation and cited F584, F677, and F925. The census at the time of the survey was 53 and the facility is licensed for 60 beds.			F0000			
F0584 SS = D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition;			F0584			

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 reverse for further 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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255319		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 06/25/2026	
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
F0584 SS = D	Continued from page 1 §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is NOT MET as evidenced by: Based on observation, staff interview, and record review, the facility failed to maintain a clean and home-like environment by failing to ensure a bedside fan used by a resident was maintained free of dust accumulation for one (1) of 53 residents reviewed. Resident #3 Findings Include: Record review of the facility's policy "Home-Like Environment Policy" with no revision date, stated, "The facility will strive to maintain a clean, safe, comfortable, well-lit, temperature-controlled environment with home-like furnishings...". During observation of Resident #3's room on 6/22/2026 at 10:30 AM, a bedside fan used by the resident was observed with an accumulation of dust covering the fan blades and the exterior protective cover. The fan was positioned next to the resident's bed and was available for resident use. The accumulation of dust on the fan blades and exterior protective cover indicated the fan had not been maintained in a clean condition necessary to provide a clean resident environment. On 06/24/2026 at 8:30 AM during an interview and observation of Resident #3's room with the Director of Nursing (DON), she confirmed there was dust throughout the fan and stated, "This should have been cleaned, and it is the expectation of the facility for fans to be free of dust accumulation." Record review of Resident #3's "Admission Record" revealed the facility admitted the resident on 6/16/2023 with diagnoses including Hemiplegia and Hemiparesis following Cerebral Infarction. A record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 3/11/2026 revealed under section C, a Brief Interview for Mental Status (BIMS) summary score of 5 which indicated Resident #3 had severe cognitive			F0584			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255319		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 06/25/2026	
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	
F0584 SS = D	Continued from page 2 impairment.	F0584					
F0677 SS = D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) \$483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is NOT MET as evidenced by: Based on observations, interviews, record review, and facility policy review, the facility failed to provide the necessary care and services to maintain personal hygiene and grooming, including physician-ordered nail care and daily clothing changes, for one (1) of eighteen (18) sampled residents (Resident #57). Findings Include: Record review of facility policy titled "Activities of Daily Living Policy" revealed, "It is the policy of this facility to provide the care and services necessary to maintain or improve each resident's ability to perform Activities of Daily Living, unless the resident's clinical condition demonstrates that such improvement is not possible. Activities of Daily Living include bathing, dressing, grooming, toileting, transferring, ambulation, eating, and personal hygiene." Record review of "Order Listing Report" revealed "Trim fingernails monthly and/or PRN (as needed)." On 6/22/2026 at 11:10 AM, an observation revealed Resident #57's fingernails were approximately one (1) inch long with a brown substance present underneath the nails. During interview, Resident #57 stated she did not prefer her fingernails to be long and reported she had received a shower that morning, but her nails had not been trimmed. On 6/23/2026 at 11:37 AM, an observation revealed Resident #57's fingernails remained approximately one (1) inch long with a brown substance present underneath the nails. Observation also revealed Resident #57 was wearing the same clothing observed the previous day. Resident #57 stated no one had changed her clothes since the day before.	F0677					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255319		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 06/25/2026	
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
F0677 SS = D	Continued from page 3 On 6/23/2026 at 11:57 AM, Certified Nursing Assistant (CNA) #1 confirmed Resident #57's fingernails were long with a brown substance present underneath the nails. Upon observing the resident's fingernails, CNA #1 stated, "Wow! Those are long!" CNA #1 further confirmed the resident's clothing should be changed daily and as needed if soiled. During an interview on 6/24/2026 at 9:10 AM, the Director of Nursing (DON) stated her expectation was that residents' fingernails be kept clean and trimmed. The DON confirmed Resident #57's long fingernails had been observed upon admission but had not been addressed. The DON also confirmed residents should be changed into pajamas each night and into clean clothing each morning. Record review of "Admission Record" revealed Resident #57 was admitted to facility on 6/18/2026 with a diagnosis of Displaced Fracture of Distal Pole of Navicular (Scaphoid) Bone of Right Wrist, Subsequent Encounter for Fracture with Routine Healing. Record review of Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 6/25/2026 revealed under Section C, a Brief Interview for Mental Status (BIMS) summary score of 8 indicating that Resident #57 was moderately cognitively impaired.			F0677			
F0925 SS = D	Maintains Effective Pest Control Program CFR(s): 483.90(i)(4) §483.90(i)(4) Maintain an effective pest control program so that the facility is free of pests and rodents. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, record review, and facility policy review, the facility failed to maintain effective pest control for one (1) of 33 resident occupied rooms. Resident #34 Findings Include: Record review of facility policy titled "Pest Control			F0925			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255319		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 06/25/2026	
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
F0925 SS = D	Continued from page 4 Policy" revealed, "It is the policy of this facility to maintain a year-round pest control program to minimize the infestation of insect pests and rodents in the facility..." On 6/22/2026 at 2:30 PM and on 6/24/2026 at 8:55 AM, observation revealed a continuous line of ants extending from the countertop in the resident's room, approximately 3 feet above the floor, down the wall next to the countertop, and continuing along the wall to the closet. Resident #34 stated she had ant bites on her right upper arm. Observation revealed approximately three (3) small red areas, each about the size of the tip of a pen, with scratch marks present on the upper right arm. Resident #34 was observed scratching the affected area. On 6/22/2026 at 2:40 PM, the Director of Nursing (DON) observed and confirmed the presence of ants on the countertop, wall, and floor near the closet in Resident #34's room. The DON also observed and confirmed approximately three (3) small red circular areas with scratch marks on the resident's right upper arm. On 6/22/2026 at 3:05 PM an interview with the Administrator confirmed that it had been an ongoing problem, but they thought they had taken care of it. On 6/24/2026 at 9:00 AM, Certified Nursing Assistant (CNA) #1 observed and confirmed the presence of ants along the wall next to the countertop and on the countertop in Resident #34's room. Record review of "Admission Record" revealed Resident #34 was admitted to facility on 2/3/2025 with a diagnosis of Type 2 Diabetes Mellitus with Hyperglycemia. Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 4/22/2026 revealed under Section C, a Brief Interview for Mental Status (BIMS) summary score of 15 indicating Resident #34 was cognitively intact.			F0925			