

Mississippi State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(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	
M0000	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 the Minimum Standards for Institutions for the Aged or Infirm, state licensure requirements and cited M610 and M970. The census at the time of the survey was 53 and the facility held a license for 60 beds.		M0000				
M0610	45.21.2 Activities of daily living Activities of daily living. Each resident shall receive assistance as needed with activities of daily living to maintain the highest practicable well being. These shall include, but not be limited to: 1. Bath, dressing and grooming; 2. Transfer and ambulate; 3. Good nutrition, personal and oral hygiene; and 4. Toileting. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Level II 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		M0610				

Office of Primary Care and Health Systems Management

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

Mississippi State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(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	
M0610	Continued from page 1 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. 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.		M0610				

Mississippi State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(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	
M0970	45.33.4 Control of insects, rodents, etc. Control of insects, rodents, etc. The facility shall be kept free of ants, flies, roaches, rodents, and other insects and vermin. Proper methods for their eradication and control shall be utilized. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Level II 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 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.		M0970				

Mississippi State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(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
M0970	Continued from page 3 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.			M0970			