

Mississippi State Department of Health

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| <b>STATEMENT OF DEFICIENCIES<br/>AND PLAN OF CORRECTIONS</b>    |                                                                                                                                                                                                                                                                                                                                                                                                            | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER: |  | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING<br>B. WING                                                    |                                                                                                                          | (X3) DATE SURVEY COMPLETED<br><b>06/24/2026</b> |                            |
| NAME OF PROVIDER OR SUPPLIER<br><b>SUNPLEX SUB-ACUTE CENTER</b> |                                                                                                                                                                                                                                                                                                                                                                                                            |                                                       |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>6520 SUNSCOPE DRIVE , OCEAN SPRINGS, Mississippi, 39564</b> |                                                                                                                          |                                                 |                            |
| (X4) ID<br>PREFIX<br>TAG                                        | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                               |                                                       |  | ID<br>PREFIX<br>TAG                                                                                     | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE<br>APPROPRIATE DEFICIENCY) |                                                 | (X5)<br>COMPLETION<br>DATE |
| M0000                                                           | Initial Comments<br><br>The State Agency (SA) conducted one (1) Complaint Investigations (CI MS #3049813), at the facility on 6/24/26. CI MS #3049813 was investigated related to Nursing Services. During the survey, the SA determined the facility was in compliance with the Minimum Standards for Institutions for the Aged or Infirm, state licensure requirement. There were no deficiencies cited. |                                                       |  | M0000                                                                                                   |                                                                                                                          |                                                 |                            |

Office of Primary Care and Health Systems Management

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