

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 04/08/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255319	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/24/2025
NAME OF PROVIDER OR SUPPLIER Sunshine Health Care, Inc		STREET ADDRESS, CITY, STATE, ZIP CODE 1677 Highway 9 North Pontotoc, MS 38863	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff interview and facility policy review the facility failed to ensure that the Minimum Data Set (MDS) assessment was coded accurately for a serious mental illness (Resident #10) and for the use of anticoagulant medications (Resident # 1, #3, #7, #21 and #33) for six (6) of 32 sampled residents. Findings include: Record review of the facility policy titled, Resident Assessment Instrument (RAI) Policy with no revision date revealed, It is the policy of this facility that the RAI will be done as follows: According to the guidelines specified by CMS (Centers for Medicare and Medicaid Services). Resident #1 Record review of Order Summary Report during initial pool revealed Resident #1 was not on an anticoagulant medication but was on Plavix, an antiplatelet medication. The resident was coded on the MDS assessment as being on anticoagulant and antiplatelet medication. Record review of Resident #1's Order Summary Report revealed an order dated 4/4/25 for Plavix 75 milligrams (mg) by mouth one time a day for Peripheral Vascular Disease. Review revealed there was no order for an anticoagulant medication. Record review of Resident #1's Minimum Data Set (MDS) Section N dated 7/7/25 revealed the resident was coded for receiving an anticoagulant. Record review of the admission Record revealed Resident #1 was admitted to the facility on [DATE] and diagnoses included Unspecified Atrial Fibrillation and Peripheral Vascular Disease. Resident #3 A record review of Resident #3's "Order Summary Report" with active orders as of 7/23/25 revealed an order dated 6/26/25 for Plavix 75 mg by mouth one time per day. There were no orders identified for an anticoagulant. A record review of Resident #3's MDS with an ARD of 7/03/25 under section N, revealed that Resident #3 was coded as being on an anticoagulant. A record review of the admission Record revealed Resident #3 was admitted by the facility on 6/26/25 with a diagnosis of Metabolic Encephalopathy. (continued on next page)		

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 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

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #7 Record review of MDS Section N dated 6/9/25 revealed Resident #7 was coded as receiving an anticoagulant medication. Record review of Resident #7's Order Summary Report revealed an order dated 1/2/24 for Clopidogrel (Plavix) 75 mg by mouth daily for Peripheral Vascular Disease. Review revealed there was no order for an anticoagulant medication. Record review of Resident #7's admission Record revealed she was admitted to the facility on [DATE]. Diagnoses included Stage 3 Chronic Kidney Disease and Peripheral Vascular Disease. Resident #21 A record review of the "Order Summary Report" dated 07/23/25, revealed an order for Plavix 75 mg by mouth one time per day. There were no orders identified for an anticoagulant. A record review of MDS with an ARD of 04/23/25 under section N, revealed that Resident #21 was on an anticoagulant. A record review of the admission Record revealed Resident #21 was admitted by the facility on 10/08/24 with a diagnosis of Diabetes Mellitus. Resident #33 A record review of the MDS with an ARD of 04/24/25 under section N, revealed that Resident #33 was on an anticoagulant. A record review of "Order Summary Report" dated 07/23/25, revealed an order for Plavix 75 mg by mouth one time per day. There were no orders identified for an anticoagulant. A record review of the admission Record revealed Resident #33 was admitted by the facility on 01/20/25 with a diagnosis of Metabolic Encephalopathy. During an interview with the Registered Nurse (RN) MDS Coordinator on 7/22/25 at 1:30 PM, she revealed that Resident #1, #3, #7, #21 and #33 were on Plavix (Clopidogrel) and aspirin, and she coded Plavix as an anticoagulant and aspirin as an antiplatelet. She stated she was unaware that Plavix was an antiplatelet and not an anticoagulant medication and confirmed she should have coded this as an antiplatelet. She confirmed the MDS represents the care and condition of the resident and should be coded accurately, and she failed to do this when an antiplatelet was coded inaccurately as an anticoagulant. During an interview on 7/22/25 at 2:20 PM, the Director of Nursing (DON) confirmed that Plavix was an antiplatelet, not an anticoagulant medication. She stated her expectation was for the MDS, which represents the condition of the residents, to be accurately completed. She confirmed the facility failed to accurately complete the MDS assessment for these residents. Resident #10 (continued on next page)		

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident # 10's Significant Change MDS with an ARD of 1/9/25, revealed Section A 1500 coded as No, Is the resident currently considered by the state level II PASRR (Preadmission Screening and Resident Review) process to have serious mental illness and/or intellectual disability or a related condition? Record review of Resident # 10's Summary of Findings Report, from the PASRR Office, dated 8/18/23, under Mental Health revealed the individual meets criteria for having a diagnosis of mental illness as defined by PASRR. During an interview with the MDS Coordinator on 7/22/25 at 2:45 PM, she verified that the Significant Change MDS with an ARD of 1/9/25, for Resident # 10 was coded incorrectly. She agreed that the MDS should be coded correctly to ensure that the resident is receiving the correct level of care. In an interview with the Director of Nursing (DON), on 7/22/25 at 3:00 PM she agreed that it was her expectation that the MDS would be coded correctly. A record review of the admission Record revealed Resident #10 was admitted by the facility on 5/19/22 with diagnoses of Schizoaffective Disorder and Major Depressive Disorder.		