STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255244	A. Building B. Wing	09/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sunplex Sub-Acute Center	6520 Sunscope Drive Ocean Springs, MS 39564

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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Based on observation, interviews, record review, and facility policy review, the facility failed to provide adequate supervision to prevent an elopement for one (1) of four (4) sampled residents, Resident #1. On 9/17/25, Resident #1, who had a Brief Interview for Mental Status (BIMS) score of six (6), and was identified by the facility as an elopement risk, was assisted out of the front door by a Dietary Aide (DA) who thought she was a visitor. She remained outside the facility for approximately 35 minutes, during which the DA left the facility parking lot at approximately 8:50 PM. Resident #1 was found at 9:05 PM knocking on the front entrance door. The facility's failure to provide supervision placed Resident #1 and other vulnerable residents at risk for serious injury, serious harm, serious impairment, or death. The situation was determined to be an Immediate Jeopardy (IJ) and Substandard Quality of Care (SQC), which began on 9/17/25, when Resident #1 exited the facility. The State Agency (SA) notified the Administrator of the IJ on 9/23/25 at 2:00 PM and provided an IJ Template. Based on the facility's implementation of corrective actions on 9/18/25, the SA determined the IJ and SQC to be Past Non-Compliance (PNC) and the IJ was removed as of 9/19/25 prior to the SA's entrance on 9/22/25. Findings include:A review of the facility's policy, Elopement/Unsafe Wandering Plan, dated February 7, 2012, revealed, .It is the policy of this facility to protect the resident from harm while providing care in a manner that helps promote quality of life in a safe environment.Definitions.3. Elopement-Elopement occurs when a resident leaves the premises or a safe area without authorization. A record review of the facility's investigation revealed on 9/17/2025, at 9:00 PM, Certified Nurse Assistant (CNA) #1, identified that Resident #1 was not in the common area or in her room when she returned from her lunch break. The Registered Nurse/Minimum Data Nurse (RN/MDS) was in the facility and was notified that Resident #1 was not on her side of the building. The RN/MDS nurse immediately called a Code W (elopement) and initiated a search of the building and perimeter. CNA #2 found Resident #1 who was knocking on the front door at 9:05 PM while searching in her assigned area; Resident #1 was dressed appropriately for the weather and had her purse on her shoulder. Resident #1 was escorted back into the building with no issues of distress noted. The Administrator and the Director of Nurses (DON) were notified of the incident. The RN/MDS completed a body audit with no signs or symptoms of injury. The RN/MDS completed a head count of all current residents in the facility, and all residents were accounted for. She also notified the medical provider and Resident Representative (RR). The Administrator arrived at the facility and checked that all doors were functioning properly. The root cause analysis determined by the Administrator and DON found that Resident #1 followed a dietary employee while he was leaving at the end of his shift. It was determined through interviews that the dietary employee was unaware that Resident #1, was a resident and was under the impression that she was a visitor. A record review of the admission Record revealed the facility admitted Resident #1 on 9/16/25 with current diagnoses including Wernicke's encephalopathy and vascular dementia. A record review of the BIMS (Brief Interview for Mental Status) Interview MDS, dated 9/16/25, revealed Resident #1 had a BIMS score of 6, which indicated her cognition was severely impaired. A record review of the local weather report revealed on 9/17/25 from 7:55 PM to 8:55 PM, the temperature was 83 degrees and clear.On 9/22/25 at 8:30 PM, during an observation of the facility and surrounding area, the facility is located approximately 925 feet from a four-lane highway and is situated within an industrial complex with multiple surrounding commercial buildings. A wooded area borders the south side of the property. The facility grounds include a paved parking lot with designated spaces for staff and visitors, and sidewalks providing access to the front entrance. Multiple exterior lights were observed around the building perimeter, including at the front entrance and doorways. There are no fencing or restricted barriers observed between the facility grounds and the surrounding industrial area.On 9/22/25 at 9:15 PM, during an interview with CNA #1, she confirmed that she was assigned to Resident #1 on 9/17/25. She reported that she last observed the resident sitting in the main lobby prior to leaving for her scheduled lunch break at approximately 8:30 PM. CNA #1 stated that when she returned from break around 9:00 PM, Resident #1 was not in her room or in the lobby. She immediately notified the RN/MDS nurse and other staff that the resident was missing, and a facility-wide search was initiated. At approximately 9:05 PM, CNA #2 located Resident #1 knocking on the facility's front door. CNA #1 confirmed that she was aware the resident was care-planned as an elopement risk, with 15-minute checks in place and identification in the wander book. She stated the facility followed its elopement policy, secured exits, and ensured all residents were accounted for. She further reported that after the incident, she was included in an in-service on elopement prevention and