

MSDH - Health Facilities Licensure and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 24GG	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 08/01/2023
--	---	---	---

NAME OF PROVIDER OR SUPPLIER GULFPORT CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 11240 CANAL ROAD GULFPORT, MS 39503
---	---

(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) COMPLETE DATE
M 000	<p>Initial Comments</p> <p>The State Agency (SA) conducted a Complaint Investigation (CI), MS# 22101, at the facility from 7/31/23 to 8/1/23. The SA did not substantiate MS #22101 for for allegations of Infection Control and Physical Environment. During the survey, the SA determined the facility was in compliance with the Mississippi Regulations for Minimum Standards for Institutions for Aged or Infirm with no deficiencies cited.</p>	M 000		

Mississippi State Department of Health LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Electronically Signed	TITLE	(X6) DATE 08/07/23
--	-------	------------------------------