

MSDH - Health Facilities Licensure and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 24GC	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 06/20/2024
NAME OF PROVIDER OR SUPPLIER COASTAL HEALTH AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1530 BROAD AVE GULFPORT, MS 39501		
(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	Initial Comments The State Agency (SA) conducted Complaint Investigations (CIs), MS #25236, MS #25240, MS #25261, MS #25330, MS #25386, and MS #25407, at the facility from 6/17/24 through 6/20/24. MS #25236 was investigated related to resident rights. MS #25240 was investigated related to staffing, accidents/falls, responsible party not being informed, abuse and being over sedated. MS #25261 was investigated related to rehabilitation services, resident not being turned, facility staffing, cold food not palatable, and call bell not being answered. MS #25330 was investigated related to roaches in the facility, no pressure sore precautions, body odor, and staffing. MS #25386 was investigated related to incontinent care. MS #25407 was investigated for death in the facility. 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.	M 000		

Mississippi State Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

06/26/24