

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255142	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 07/23/2024
NAME OF PROVIDER OR SUPPLIER OCEAN SPRINGS HEALTH & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1199 OCEAN SPRINGS ROAD OCEAN SPRINGS, MS 39564		
(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) COMPLETION DATE
F 000	INITIAL COMMENTS The State Agency (SA) conducted two (2) Complaint Investigations (CI MS #25262 and CI MS #25915), at the facility on 07/23/24. CI MS #25262 was investigation regarding Misappropriation of Property, Physical Environment, and Physician Services and CI MS #25915 was investigated regarding Resident Abuse and Safety. During the survey, the SA determined the facility was in compliance with the requirements for participation in Medicare and Medicaid and there were no deficiencies cited. The facility had a census of 100 and was licensed for 115 beds.	F 000			

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

Electronically Signed

TITLE

(X6) DATE

08/07/2024