

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 07/07/2025
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	Initial Comments The State Agency (SA) conducted a Complaint Investigation (CI), MS #29413, at the facility on 7/7/25. MS #29413 was investigated for resident left wet, call bells not answered, injury of unknown origin, verbal abuse (employee to resident), and resident not treated with dignity. Although there were no deficiencies cited during the survey, the facility will remain out of compliance with the Minimum Standards for Institutions for the Aged or Infirm, state licensure requirement due to deficiencies cited on the 06/05/25 survey.	M 000		

Mississippi State Department of Health

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

TITLE

(X6) DATE

Electronically Signed

07/08/25