

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/25/2025  
FORM APPROVED  
OMB NO. 0938-0391

|                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                            |                                                                                                                          |                            |                                                                    |
|-----------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|----------------------------|--------------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>255341</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____                                                     |                            | (X3) DATE SURVEY<br>COMPLETED<br><br><b>R</b><br><b>07/07/2025</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>GULFPORT CARE CENTER</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                            | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>11240 CANAL ROAD</b><br><b>GULFPORT, MS 39503</b>                            |                            |                                                                    |
| (X4) ID<br>PREFIX<br>TAG                                        | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                               | ID<br>PREFIX<br>TAG                                                        | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETION<br>DATE |                                                                    |
| {F 000}                                                         | <p>INITIAL COMMENTS</p> <p>The State Agency (SA) conducted a follow-up revisit at the facility on 7/7/25 related to the Annual and Complaint Survey that was conducted 6/2/25 through 6/5/25. The SA found the facility to be in compliance with the requirements of participation in Medicare and Medicaid and recommends the facility be placed back in compliance effective 7/7/25.</p> <p>The facility held a license for 90 beds and the census at the time of the survey was 66.</p> | {F 000}                                                                    |                                                                                                                          |                            |                                                                    |

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

TITLE

(X6) DATE

Electronically Signed

07/10/2025

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.