

MSDH - Health Facilities Licensure and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 24LA	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 05/07/2021
NAME OF PROVIDER OR SUPPLIER LAKEVIEW NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 16411 ROBINSON 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 survey from 5/5/21 through 5/7/21 to investigate (CI) MS # 17788 for abuse, unqualified staff, no pressure sore prevention, no rehabilitation services and dead termites in the window sill. During the survey, the SA was unable to substantiate CI MS #17788 and determined the facility was in compliance with the Minimum Standards for Institutions for the Aged or Infirm. The facility census was 83 and licensed for 105 beds.	M 000		

Mississippi State Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE