

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255092		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 04/15/2026	
NAME OF PROVIDER OR SUPPLIER COASTAL HEALTH AND REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 1530 BROAD AVE , GULFPORT, Mississippi, 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) COMPLETION DATE
F0000	INITIAL COMMENTS The State Agency (SA) conducted seven (7) Complaint Investigations (CI MS #2979025, CI MS #2969324, CI MS #2969707, CI MS #2969222, CI MS #2799897, CI MS #2794912, and CI MS #2793062, at the facility from 4/13/26 to 4/15/26. CI MS #2979025 was investigated for discharge planning, CI MS #2969324 was investigated for falls, CI MS #2969707 was investigated for staffing and residents left wet and soiled, CI MS #2969222 was investigated for falls, CI MS #2799897 was investigated for falls and nursing services, CI MS #2794912 was investigated for resident rights related to visitation, and CI MS #2793062 was investigated related to supplies and improper incontinence care. During the survey, the SA determined the facility was in compliance with the requirements of participation in Medicare and Medicaid and there were no deficiencies cited. The facility held a license for 121 beds, with a census of 180.			F0000			

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 reverse for further 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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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