STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255341	A. BUILDING _____ B. WING _____	C 10/21/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GULFPORT CARE CENTER	**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) COMPLETION DATE
F 000	INITIAL COMMENTS A annual survey and Complaint Investigations (CI) MS #17383, CI MS #17426, CI #17463, CI #17961, and CI MS #18132 was conducted by the State Agency (SA) from 10/18/2021 through 10/21/2021. The facility was found to be in compliance with the requirements for participation in Medicare and Medicaid. The SA did not substantiated the complaints for CI MS #17383, CI MS #17426, CI MS #17463, CI MS #17961 and CI MS # 18132 related to not answering call lights in a timely manner, resident not receiving water, facility did not notify the family of change in residents' condition and physician not following up on the resident, resident did not receive oxygen at 4L/min routinely, the resident did not receive IV fluids ordered by his primary physician, the resident did not receive his baths, resident was discharged from facility with skin breakdown that she did have upon admission, Quality of Care/services not performed per Plan of Care & Physician order, and Infection Control/wound care. The facility has a license for 90 beds with a census of 67.	F 000		

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

Electronically Signed | 11/12/2021

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.