

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

PRINTED: 04/14/2021
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255142	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 03/29/2021
NAME OF PROVIDER OR SUPPLIER OCEAN SPRINGS HEALTH & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1199 OCEAN SPRINGS ROAD OCEAN SPRINGS, MS 39564		
(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 The State Survey Agency (SA) conducted a complaint investigation (CI MS #17662, CI MS #17667, CI MS #17674, CI MS #17675) on 3/29/21. The SA determined the facility was in compliance with Medicare and Medicaid requirements for participation. The facility held a license for 115 beds, with a census of 89. CI MS #17662 The result of the investigation was unsubstantiated with no deficiencies cited for Quality of Care related to Responsible Party Not Notified. The SA determined the facility was in compliance with Medicare and Medicaid requirements for participation. CI MS #17667 The result of the investigation was unsubstantiated with no deficiencies cited for Quality of Care related to Resident Left Soiled for an Extended Time, Medication Not Given According Physician, Resident Neglect related to Assess, Dietary Services, and Rehabilitation Services. The SA determined the facility was in compliance with Medicare and Medicaid requirements for participation. CI MS #17674 The result of the investigation was unsubstantiated with no deficiencies cited for Quality of Care related to Responsible Party Not Notified, No Pressure Sore Prevention, Resident Not Repositioned, and Inappropriate Feeding Assistance, Resident Neglect related to Pressure Sore. The SA determined the facility was in compliance with Medicare and Medicaid requirements for participation.	F 000			

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

TITLE

(X6) DATE

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.

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F 000	Continued From page 1 CI MS #17675 The result of the investigation was unsubstantiated with no deficiencies cited for Quality of Care related to Resident Left Wet for Extended Time, Resident Neglect related to Assess. The SA determined the facility was in compliance with Medicare and Medicaid requirements for participation.	F 000			