STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255142	A. BUILDING _____ B. WING _____	C 03/29/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OCEAN SPRINGS HEALTH & REHABILITATION CENTER	**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	F 000		

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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255142	A. BUILDING _____ B. WING _____	C 03/29/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OCEAN SPRINGS HEALTH & REHABILITATION CENTER	**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	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		