

MSDH - Health Facilities Licensure and Certification

|                                                                 |                                                                                                                                                                                                                                                                                                                               |                                                                                               |                                                                                                                          |                                                                    |
|-----------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION             |                                                                                                                                                                                                                                                                                                                               | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>24GG</b>                      | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   | (X3) DATE SURVEY<br>COMPLETED<br><br><b>C</b><br><b>12/21/2021</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>GULFPORT CARE CENTER</b> |                                                                                                                                                                                                                                                                                                                               | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>11240 CANAL ROAD</b><br><b>GULFPORT, MS 39503</b> |                                                                                                                          |                                                                    |
| (X4) ID<br>PREFIX<br>TAG                                        | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                  | ID<br>PREFIX<br>TAG                                                                           | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE                                           |
| M 000                                                           | Initial Comments<br><br>The State Agency (SA) determined during a Complaint survey, CI: 18257 conducted from 12/20/2021 to 12/21/2021. The SA determined the facility was in compliance with the Minimum Standards of Operation for Institutions for the Aged or Infirm, state licensure requirements, No deficiencies cited. | M 000                                                                                         |                                                                                                                          |                                                                    |

Mississippi State Department of Health

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

TITLE

(X6) DATE

Electronically Signed

07/14/22