

MSDH - Health Facilities Licensure and Certification

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| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>300S</b>                            | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   | (X3) DATE SURVEY<br>COMPLETED<br><br><b>08/11/2022</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>OCEAN SPRINGS HEALTH &amp; REHABILITATION CENTI</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>1199 OCEAN SPRINGS ROAD<br/>OCEAN SPRINGS, MS 39564</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                                                                                      | <p>Initial Comments</p> <p>The State Agency (SA) conducted a Complaint Investigation (CI), MS #19429 and MS #19448 at the facility from 08/10/22 through 08/11/22. During the survey, the SA determined the facility was not in compliance with the Mississippi Regulations for Minimum Standards for Institutions for the Aged or Infirm, state licensure requirements. MS #19448 was not substantiated for neglect, pressure sores, infection control, nursing services, and care not received per Physician's Orders. MS #19429 was substantiated for a medication diversion and M500 was cited.</p> | M 000                                                                                               |                                                                                                                          |                                                        |

Mississippi State Department of Health

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

TITLE

(X6) DATE

Electronically Signed

08/29/22