STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255111	A. BUILDING _____ B. WING _____	01/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WEST POINT COMMUNITY LIVING CENTER	2056 N ESHMAN AVENUE WEST POINT, MS 39773

(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 Agency (SA) conducted an annual recertification survey and a complaint investigation (CI) for CI MS# 23718 at the facility from 1/2/24 through 1/4/24. During the survey, the SA determined the facility was not in compliance with Medicare and Medicaid requirements for participation and a deficiency was cited at F880 related to a treatment cart being taken into a resident room. The facility was found to be in compliance with CI MS #23718 related to abuse and no deficiencies were cited related to the complaint investigation. The census at the time of the survey was 69, and the facility was licensed for 100 beds at the time of survey.	F 000		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals	F 880		2/6/24

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

Electronically Signed | 01/11/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255111	A. BUILDING _____ B. WING _____	01/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WEST POINT COMMUNITY LIVING CENTER	2056 N ESHMAN AVENUE WEST POINT, MS 39773

(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 880	Continued From page 1	F 880		

providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.
(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and
(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.

§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.

§483.80(e) Linens.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255111	A. BUILDING _____ B. WING _____	01/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WEST POINT COMMUNITY LIVING CENTER	2056 N ESHMAN AVENUE WEST POINT, MS 39773

(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 880	Continued From page 2 Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and facility policy review, the facility failed to prevent the spread of infection as evidenced by placement of a treatment cart inside a resident room during treatment care for one (1) of three (3) survey days. Findings include: Record review of facility policy titled, "Standard Precautions" dated May 30, 2012, revealed, "Standard Precautions will be used in the care of all residents regardless of their diagnoses or suspected or confirmed infection status. Standard Precautions presume that all blood, membranes may contain transmissible infectious agents..." Record review of facility policy titled, "Infection Control Program" dated February 1, 2008, revealed, "The facility will establish and maintain an Infection Control Program focused on preventing the transmission of infectious disease in the long-term care setting. Purpose: Decrease the risk of infection for residents and staff; Monitor for the occurrence of infections and implement control measures; Identify and correct improper infection control practices; Insure compliance with federal and state infection control guidelines..."	F 880	1. On 1/2/2024 the lock to the treatment cart was repaired. Verbal coaching with nurse #1 on infection control practices and standard precautions completed by Director of Nursing on 1/2/2024. 2. All residents have the potential to be affected by the alleged deficient practices. 3. On 1/4/2024, staff in-services began on infection control, standard precautions, cleaning reusable equipment, and addressing broken locks. New Treatment Cart ordered 1/11/2024. 4. Beginning 1/11/2024, the Director of Nursing will conduct infection control rounds 2 times per week for 2 weeks, then weekly for 2 weeks, then monthly x 2. Beginning 1/11/2024, the Director of Nursing will perform lock checks to ensure locks are functioning properly on the treatment cart weekly x 4 weeks then monthly x 2. All results of audits will be brought to Quality Assurance and Performance Improvement meeting by the Director of Nursing to be reviewed by the IDT team. Results will be followed in Quality Assurance and Performance Improvement for 3 months. Quality Assurance and Performance Meeting will be conducted on 2/1/2024. With Date Certain: 2/6/2024.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255111	A. BUILDING _____ B. WING _____	01/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WEST POINT COMMUNITY LIVING CENTER	2056 N ESHMAN AVENUE WEST POINT, MS 39773

(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 880	Continued From page 3	F 880		

During the initial tour on 1/2/24 at 10:20 AM, an observation revealed Licensed Practical Nurse (LPN) #1 coming out of resident room #318. The treatment cart with items on the top of the cart was inside the resident's room. LPN #1 then turned around and stepped back into the room and pushed the cart from the room into the hallway. During the interview, LPN #1 stated she was in resident's room to perform wound care and had taken the treatment cart into the room because the lock on the cart was broken and she did not want to leave the unlocked cart containing treatment supplies unattended in the hallway. She stated she had also taken this cart into other residents' rooms to do their treatments and she did not clean the cart between residents and she did not remove items from the open top of the cart. She stated that when she took the cart into the residents' rooms, she was focused on the safety concern of leaving an unlocked supply cart unattended and did not think about the infection control risk. She stated for proper infection control and for decreasing the spread of infection, she should have left the cart in the locked storage room and taken only the items needed for the resident's treatment into the room. Observation at that same time was made of LPN #1 attempting to lock the cart and when the lock was pressed in, it popped back out and did not remain in locked position.

During an interview on 1/2/24 at 11:25 AM, the Director of Nursing (DON) stated that taking a medication cart or a treatment cart into a resident's room was "a big no, no", and this could spread infections from one resident to another resident. She confirmed that by taking a treatment cart into residents' rooms, the facility

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255111	A. BUILDING _____ B. WING _____	01/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WEST POINT COMMUNITY LIVING CENTER	**2056 N ESHMAN AVENUE WEST POINT, MS 39773**

(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 880	Continued From page 4 failed to decrease the likelihood of the spread of infection. She also confirmed the facility failed to ensure the proper techniques for infection control were followed. She confirmed the lock on the cart was being repaired, but it had been "broken for a while", and during that time to decrease the risk for the spread of infection, the cart should have been left in a locked room and only the necessary supplies should have been removed and taken into the resident's room.	F 880		