

MSDH - Health Facilities Licensure and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13CI	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 03/20/2024
NAME OF PROVIDER OR SUPPLIER WEST POINT COMMUNITY LIVING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 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) COMPLETE DATE
M 000	Initial Comments The State Agency (SA) conducted a Complaint Investigation (CI) MS #24321 and CI MS #24334 at the facility on 03/20/24. During the survey, the SA determined the facility was in compliance with the Minimum Standards of Operation for Institutions for the Aged or Infirm, state licensure requirements and there were no deficiencies cited. The facility held a license for 100 beds at the time of the survey, and the facility census was 70.	M 000		

Mississippi State Department of Health

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

TITLE

(X6) DATE

Electronically Signed

04/06/24