

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 10/23/2024
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 survey, MS#26300 at the facility from 10/22/24 through 10/23/24. During the survey, the SA determined that the facility was in compliance with the Minimum Standards of Operation for Institutions for the Aged or Infirm. The SA did not substantiate the complaint for resident abuse, resident rights, or quality of care and cited no citations. The census at the time of the survey was 69 with a bed capacity of 100 beds.	M 000		

Mississippi State Department of Health

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

TITLE

(X6) DATE

Electronically Signed

10/30/24