MSDH - Health Facilities Licensure and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13CI	A. BUILDING: _____ B. WING _____	C 09/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WEST POINT COMMUNITY LIVING CENTER	**1122 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, MS00018063 at the facility on 09/16/2021. During the survey, the SA determined that the facility was in compliance with the Minimum Standards of Operation for the institutions for the Aged or Infirmed and state licensure requirements. The SA determined the complaint allegations related to quality of care/treatment for services not received per physician order, call bell not being answered timely, responsible party not being notified and residents not being assessed were not substantiated and no deficiences were cited. The facility was licensed for 100 beds with a census of 67 at the time of the survey.	M 000		

Mississippi State Department of Health

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