

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 04/20/2021
NAME OF PROVIDER OR SUPPLIER WEST POINT COMMUNITY LIVING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 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, MS #17748 at the facility from 04-19-2021 to 04-20-2021. During the survey, the SA determined that the facility was in compliance with the requirements for the Aged and Infirm. The SA did not substantiate the complaint for Resident/Patient/Client Neglect, during an incident in which a resident spilled coffee on herself causing a second degree burn to her right leg. The SA cited no deficiencies. Census was 67 out of 100 bed availability.	M 000		

Mississippi State Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE