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 _____	C 01/04/2023

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) COMPLETION DATE
F 000	INITIAL COMMENTS The State Agency (SA) conducted a complaint investigation (CI MS# 19579, CI MS#19580, CI MS# 19615, and CI MS# 19915) at the facility from 1/3/23 through 1/4/23. During the survey, the SA determined that the facility was not in compliance with the requirements of participation in Medicare and Medicaid Services. The SA identified non-compliance and cited F610 for CI MS# 19615 and CI MS# 19915 for failure to investigate resident allegations of abuse. There were no deficiencies cited for CI MS# 19579 related to pressure ulcers, assessing/monitoring, and CI MS# 19580 related to quality of care and neglect. The census at the time of the survey was 61 with a bed capacity of 100 beds.	F 000		
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified	F 610		2/3/23

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

Electronically Signed | 01/19/2023

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 _____	C 01/04/2023

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) COMPLETION DATE
F 610	Continued From page 1 appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on resident and staff interviews, record review, and facility policy review, the facility failed to thoroughly investigate an allegation of abuse for one (1) of three (3) records reviewed for abuse/neglect allegations. Resident #4 Findings include: Record review of facility policy titled, "Abuse, Neglect, Exploitation or Misappropriation - Reporting and Investigating," with revised date of 10/22, revealed, "All reports of resident abuse (including injuries of unknown origin), neglect, exploitation, or theft/misappropriation of resident property are reported to local, state and federal agencies (as required by current regulations) and thoroughly investigated by facility management. Findings of all investigations are documented and reported ...2. The administrator or the individual making the allegation immediately reports his or her suspicion to the following persons or agencies: a. The state licensing/certification agency responsible for surveying/licensing the facility; b. The local/state ombudsman; c. The resident's representative; d. Adult protective services (where state law provides jurisdiction in long term care); e. Law enforcement officials; f. The resident's attending physician; and g. The facility medical director ... Investigation Allegations 1.All allegations are thoroughly investigated. The administrator initiates investigations ..." An interview with Resident #4 on 1/3/23 at 9:45 AM, revealed the resident had an incident with a	F 610	1.On January 4, 2023, an allegation of Certified Nursing Assistant (CNA) #1 hollering at Resident #4 was reported to the Ms. Department of Health, Licensure and Certification and the MS. Attorney General's Office by Administrator (Adm). On January 4, 2023, staff that were present on November 16, 2022 were interviewed by Director of Nurses (DON). DON did a 1:1 coaching CNA #1 on November 16, 2022, to calm her voice when communicating with residents. On January 5, 2023, Social Service Director (SSD), interviewed all the Cognitively intact residents and no one had any concerns of mistreatment, abuse, or neglect. CNA #1 did not work at the facility as of January 5, 2023. 2.All residents have the potential to be affected by this alleged deficient practice. 3.Assistant Director of Nursing (ADON) will in-service all staff prior to working on the Abuse and Neglect Policy and Procedures with specific details concerning the obligation of reporting and investigation to be completed by January 30, 2023. On January 6, 2023, Regional Director of Operations (RDO) in-serviced Adm., DON, and SSD, on specific details concerning the obligation on the reporting and investigations according to the Abuse and Neglect Policy. 4.Beginning January 5, 2023, daily rounds	

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 _____	C 01/04/2023

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) COMPLETION DATE
F 610	Continued From page 2 Certified Nurse's Assistant (CNA) #1 and stated that around Thanksgiving, she used her call light and CNA #1 was loud and yelling at her and that the CNA did not physically harm her, but she spoke too loudly. During the interview, Resident #4 stated she wanted to receive the assistance she needed without the staff being disrespectful. Resident #4 revealed she reported this incident to the staff, and she did not feel that she suffered any harm or depression from this incident but felt that staff could speak nicer. An interview with Licensed Social Worker (LSW) on 1/3/23 at 4:30 PM, revealed she had a care plan meeting with Resident #4 and her family on 11/16/22 and that after the care plan meeting, she went back to Resident #4's room to see if she had any questions or concerns and she stated that Resident #4 wanted to file a grievance about an incident that occurred when Resident #4 used her call light and CNA #1 came into her room and yelled at her. LSW said she immediately sent an electronic mail (email) to the previous Administrator and the Director of Nursing (DON). She stated after the email, she met with the Administrator and the DON, and she was informed that they were not going to allow CNA #1 to be assigned to Resident #4 any longer. An interview with the DON on 1/3/23 at 5:00 PM, revealed after she learned of the allegation from the LSW, she had a one-on-one meeting with CNA #1 concerning the incident that Resident #4 had reported to the LSW, but nothing was written up, placed in CNA #1's personnel record, no further investigation was conducted. She stated CNA #1 admitted that she talked loudly and that was just the way she talked but denied yelling at the resident. The DON revealed she informed	F 610	with the residents will be conducted by the Adm. and the SSD to identify any further concerns. The rounds will be made 5 times a week X 4 weeks, then twice a week X 2 week, and weekly x2 and will interview 5 residents each week. Quality and Assurance Committee will meet on January 27, 2023 to discuss findings. Any further concerns will be reported to the Administrator for proper reporting and investigation. The results of these findings will be reported to the Quality and Assurance Committee monthly x 2 months.	

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 _____	C 01/04/2023

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) COMPLETION DATE
F 610	Continued From page 3	F 610		

CNA #1 that she was not to yell or get frustrated with the residents and to be mindful and respectful with the residents. The DON said she did not interview staff, residents, or resident's family and she did not thoroughly investigate the allegation. The DON confirmed the facility failed to investigate an allegation of abuse as required and that neither she nor the Administrator of the facility investigated this allegation of abuse.

An interview with the Administrator on 1/4/23 at 4:50 PM, revealed there was an allegation of abuse of this resident and the facility failed to thoroughly investigate the allegation and confirmed that the facility Administrator was responsible for ensuring that all allegations are completely investigated.

Record review of Grievance Log for November 2022, revealed on 11/16/22, a grievance was submitted by the Licensed Social Worker for Resident #4. Grievance Log revealed, "Aides on floor - 'raising hell and yelling at me'."

Record review of email sent from Licensed Social Worker to the Administrator and the Director of Nursing revealed the grievance concerning Resident #4, email dated 11/16/22 at 1:02 PM, from Licensed Social Worker revealed, "Good afternoon, I reviewed (Proper name removed) Resident #4's care plan with her today and she wanted to file a grievance with me. She states that her aid is always 'raising hell.' When I asked what she meant, she explained that whenever she asks for something, her aid is always rude and because of this, she doesn't want to ask for help at all. I asked her to explain what she meant. She told me this morning she asked her aid to come and turn on the heat and her aid

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 _____	C 01/04/2023

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) COMPLETION DATE
F 610	Continued From page 4	F 610		

responded by saying 'you need to stay off that light, if I come and turn the heat on, it's gone stay on till' I turn it back off'." She went on to explain that this aid is always rude to her, and it makes her feel depressed. When I asked for clarification of who she was referring to, she stated it was the lady that took her up to therapy this morning. I verified with (proper name of nurse) that it was (proper name removed) CNA #1. Because she mentioned feeling depressed and not wanting to ask for help, I will need to do an in-service again with the staff on abuse/neglect. I have attached a copy of the grievance for your records as well. I'll be checking on Resident #4 (proper name removed) periodically as well." The response from the Administrator on 11/16/22 at 1:04 PM was, "Thanks for letting us know this. Director of Nursing (DON) (proper name removed) we will need to talk to CNA #1 (proper name removed) regarding this. The response from DON (proper name removed) on 11/16/22 at 2:48 PM was, "I have addressed this with CNA #1 (proper name removed) and I have put an intervention into place and I discussed with her about abuse and neglect policy." The response from the Administrator on 11/16/22 at 2:49 PM was "OK thanks!"

Record review of the Admission Record revealed the resident was admitted to the facility on 10/8/22. Diagnoses included Muscle Weakness,Ventricular Premature Depolarization, Hypertension and Type 2 Diabetes Mellitus.

Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 12/14/22 revealed a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident was cognitively intact.

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 _____	C 01/04/2023

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) COMPLETION DATE