

Mississippi State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/03/2026	
NAME OF PROVIDER OR SUPPLIER WEST POINT COMMUNITY LIVING CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 2056 N ESHMAN AVENUE , WEST POINT, Mississippi, 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	
M0000	Initial Comments The State Agency (SA) conducted two (2) Complaint Investigations (CI MS #3016184 and CI MS #3123757) at the facility on 8/3/26. During the survey, the SA determined that the facility was not in compliance with the requirements of the Mississippi Regulations for Minimum Standards for Institutions for Aged or Infirm, state licensure requirements. The SA identified noncompliance and cited M 735 related to accurate record keeping for CI MS #3123757. There were no citations related to CI MS #3016184. Census at the time of the survey was 59 with a bed capacity of 60 beds.		M0000				
M0735 SS = D	45.25.1 Medical Records Management Medical Records Management. 1. A medical record shall be maintained in accordance with accepted professional standards and practices on all residents admitted to the facility. The medical records shall be completely and accurately documented, readily accessible, and systematically organized to facilitate retrieving and compiling information. 2. A sufficient number of personnel, competent to carry out the functions of the medical record service, shall be employed. 3. The facility shall safeguard medical record information against loss, destruction, or unauthorized use. 4. All medical records shall maintain the following information: identification data and consent form; assessments of the resident's needs by all disciplines involved in the care of the resident; medical history and admission physical exam; annual physical exams; physician or nurse practitioner/physician assistant orders; observation, report of treatment, clinical findings and progress notes; and discharge summary, including the final diagnosis.		M0735				

Office of Primary Care and Health Systems Management

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE		TITLE	(X6) DATE
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M0735 SS = D	<p>Continued from page 1</p> <p>5. All entries in the medical record shall be signed and dated by the person making the entry. Authentication may include signatures, written initials, or computer entry. A list of computer codes and written signatures must be readily available and maintained under adequate safeguards.</p> <p>6. All clinical information pertaining to the residents stay shall be centralized in the resident's medical records.</p> <p>7. Medical records of discharged residents shall be completed within sixty (60) days following discharge.</p> <p>8. Medical records are to be retained for five (5) years from the date of discharge or, in the case of a minor, until the resident reaches the age of twenty-one (21), plus an additional three (3) years.</p> <p>9. A resident index, including the resident's full name and birth date, shall be maintained.</p> <p>This LICENSURE REQUIREMENT is NOT MET as evidenced by:</p> <p>Level II Based on record review, staff interviews, and facility policy review the facility failed to ensure the clinical record was complete and accurately documented when a licensed nurse signed the Controlled Drug Receipt/Record/Disposition Form indicating she witnessed the removal and disposal of a controlled substance when she did not for one (1) of three (3) residents reviewed. Resident #1</p> <p>Findings included:</p> <p>Record review of facility policy titled "Controlled Substances Destruction Policy and Procedure" revealed "Policy: Controlled substances are subject to special handling, storage, disposal, and recordkeeping in the facility, in accordance with federal and state laws and regulations. Procedure:...2. It must be witnessed by another nurse and placed in Sharp's container for disposal. 3. Disposal is to be documented on the narcotic record on the line representing that dose and signed by administering nurse and witness nurse..."</p> <p>Record review of Resident #1's July 2026 Medication Administration Record (MAR) revealed that on</p>	M0735					

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M0735 SS = D	<p>Continued from page 2 7/03/26 and 7/06/26, the Fentanyl 12 MCG/HR patch was signed as applied by RN #1.</p> <p>Record review of the "Controlled Drug Receipt/Record/Disposition Form" for Resident #1 revealed that on 7/03/26 and 7/06/26, a Fentanyl 12 MCG/HR patch was signed as wasted by Registered Nurse (RN) #1 and Licensed Practical Nurse (LPN) #2.</p> <p>On 8/3/26 at 12:09 PM, in a telephone interview with LPN #1 she reported that on 7/09/26, when she went to apply the resident's scheduled Fentanyl patch, Resident #1 had two (2) patches on. One was dated 7/03/26 and the other was dated 7/06/26. Both patches were initialed by RN #1.</p> <p>During an interview on 8/3/26 at 12:43 PM, LPN #2 she stated facility practice required the witnessing nurse to observe disposal to ensure the patch was not diverted. She verified she signed as the witness for disposal on 7/6/26 of the 7/3/26 Fentanyl patch without actually observing removal of the patch from the resident or witnessing its disposal and acknowledged this process was not followed.</p> <p>Interview with the Director of Nursing on 8/3/26 at 1:05 PM she confirmed that the "Controlled Drug Receipt/Record/Disposition Form" for Resident #1 was not accurate.</p> <p>Record review of the "Admission Record" revealed the facility admitted Resident #1 on 10/7/25 with diagnoses that included acute on chronic right heart failure and chronic atrial fibrillation.</p>			M0735			