STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255111	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 10/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WEST POINT COMMUNITY LIVING CENTER	**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
F0000	INITIAL COMMENTS The State Agency (SA) conducted an Annual Re-certification survey along with a Complaint Investigation (CI MS#3714679) at the facility from 10/05/26 through 10/07/26. During the survey, the SA determined the facility was not in compliance with Medicare and Medicaid requirements of participation and cited F565, F641, F644, F759, and F880. The SA investigated CI#3714679 and no deficiencies were cited. The census at the time of the survey was 58 and the facility is licensed for 100 beds.	F0000		
F0565 SS = D	Resident/Family Group and Response CFR(s): 483.10(f)(5)(i)-(iv)(6)(7) §483.10(f)(5) The resident has a right to organize and participate in resident groups in the facility. (i) The facility must provide a resident or family group, if one exists, with private space; and take reasonable steps, with the approval of the group, to make residents and family members aware of upcoming meetings in a timely manner. (ii) Staff, visitors, or other guests may attend resident group or family group meetings only at the respective group's invitation. (iii) The facility must provide a designated staff person who is approved by the resident or family group and the facility and who is responsible for providing assistance and responding to written requests that result from group meetings. (iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility. (A) The facility must be able to demonstrate their response and rationale for such response. (B) This should not be construed to mean that the	F0565		

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F0565 SS = D	Continued from page 1 facility must implement as recommended every request of the resident or family group. §483.10(f)(6) The resident has a right to participate in family groups. §483.10(f)(7) The resident has a right to have family member(s) or other resident representative(s) meet in the facility with the families or resident representative(s) of other residents in the facility. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interviews, record review, and facility policy review, the facility failed to ensure a resident's complaint about nighttime noise was communicated to appropriate staff, investigated, and promptly addressed for one (1) of 10 (ten) residents reviewed for council meeting. Resident #24 Findings include: Review of the facility policy titled "Grievance Policy and Procedure" revealed the following under "Purpose: … To ensure each resident grievance will be followed up by prompt efforts to resolve grievance that the resident may have, including those with respect to the behavior of other residents...Policy: All grievances will be investigated thoroughly, and appropriate corrective action taken..." During an observation and interview on 10/05/26 at 10:32 AM, Resident #24 was sitting in his wheelchair in his room reading his Bible. He reported that his roommate played the television (TV) or radio loudly at night, preventing him from sleeping. He stated he had told staff several times and had recently told the Nurse Practitioner (NP), but nothing had been done. During the observation, the roommate was absent from the room, but the roommate's TV was on and could be heard loudly even before entering the room. A bedside radio was also on and music could be heard, on the roommate's nightstand. Record review of the psychiatric Nurse Practitioner's (NP) "Progress Notes" dated 10/01/26 revealed the following under "Subjective: ...Reports feeling that others are "putting me down on purpose" which affects his mood, environmental stressor of radio/television staying on all night causing sleep disturbance, severe persistent insomnia." The note also revealed under, "Assessment: Patient reports significant sleep disturbance due to environmental	F0565		

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F0565 SS = D	Continued from page 2 factors (radio/television staying on all night) which exacerbates underlying psychiatric condition and contributes to mood instability and irritability." The NP documented under, "Plan: Consider environmental modifications to reduce nighttime noise disturbances (TV/radio)." During an interview on 10/06/26 at 4:18 PM, the Administrator confirmed that a grievance had not been filed for Resident #24's complaint about noise levels and his inability to sleep at night. During an interview on 10/07/26 at 8:38 AM, Social Services (SS) stated she was unaware that the nighttime noise was interfering with Resident #24's sleep. She knew his roommate played the TV at night but did not know it was keeping him awake. SS confirmed the NP had not notified her of his concern. During an interview on 10/07/26 at 11:19 AM, the Director of Nursing (DON) stated that the psychiatric NP usually stopped by after visiting residents to notify her or the Assistant Director of Nursing (ADON) of new orders. The DON stated she was off the day the NP visited. She confirmed that the NP should have communicated Resident #24's concern to staff so it could be addressed promptly. During an interview on 10/07/26 at 11:30 AM, the ADON confirmed that the NP had not communicated Resident #24's concerns about noise and sleep to her. She stated, "I wound have immediately addressed it, and we could have moved him to another room or spoken to the roommate." She confirmed that the information should have been relayed to staff immediately. She acknowledged that the environmental noise could contribute to increased insomnia and irritability and affect Resident #24's mental illness. Record review of the "Admission Record" revealed the facility admitted Resident #24 on 10/03/16 with diagnoses that included schizoaffective disorder and Insomnia due to another Mental Disorder. Record review of the "Progress Notes" dated 07/13/26 revealed a Brief Interview for Mental Status (BIMS) score of 11, indicating moderate cognitive impairment.	F0565		
F0641 SS = D	Accuracy of Assessments CFR(s): 483.20(g)(h)(i)(j) §483.20(g) Accuracy of Assessments.	F0641		

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F0641 SS = D	Continued from page 3 The assessment must accurately reflect the resident's status. §483.20(h) Coordination. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. §483.20(i) Certification. §483.20(i)(1) A registered nurse must sign and certify that the assessment is completed. §483.20(i)(2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. §483.20(j) Penalty for Falsification. §483.20(j)(1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. §483.20(j)(2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is NOT MET as evidenced by: Based on interviews, record review, and facility document review, the facility failed to ensure that the Minimum Data Set (MDS) assessments accurately reflected an active psychotic disorder diagnosis for Resident #4 and one (1) MDS assessment accurately reflected pain indicators for Resident #20, affecting two (2) of 15 residents reviewed (Residents #4 and Resident #20). Findings included: Review of a document on facility letterhead dated 10/7/26 and signed by the Administrator revealed “(Proper Name) does not have a policy on the accuracy of Minimum Data Set we follow the Resident Assessment Instrument (RAI)."	F0641		

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F0641 SS = D	Continued from page 4 Resident #4 Record review of Resident #4's Level I Preadmission Screening (PAS), submitted on 2/26/2020, revealed Part B, Level II Referral Criteria, was marked "Yes" for both a diagnosis of a major mental illness and current or historical use of psychotropic medication. The primary diagnosis was listed as, unspecified psychosis not due to a substance or known physiological condition. Record review of Resident #4's Significant Change MDS assessment submitted on 9/18/2025 revealed item I5950, Psychotic Disorder (Other Than Schizophrenia), was coded "Yes." Record review of Resident #4's MDS assessment with an Assessment Reference Date (ARD) of 12/18/2025 revealed item I5950 was coded "No," indicating the resident did not have an active diagnosis of a psychotic disorder other than schizophrenia. However, review of the December 2025 Medication Administration Record (MAR) revealed the resident was prescribed and administered Seroquel 25 Milligrams (mg) and Zyprexa 5 mg for treatment of unspecified psychosis not due to a substance or known physiological condition during the assessment's seven-day look-back period. Record review of Resident #4's MDS assessment with an ARD of 3/19/2026 revealed item I5950 was coded "No." However, review of the March 2026 MAR revealed the resident was prescribed and administered Seroquel 25 mg and Zyprexa 5 mg for treatment of the same psychosis diagnosis during the assessment's seven-day look-back period. Record review of Resident #4's MDS assessment with an ARD of 6/17/2026 revealed item I5950 was coded "No." However, review of the June 2026 MAR revealed the resident was prescribed and administered Seroquel 25 mg and Zyprexa 5 mg for treatment of the same psychosis diagnosis during the assessment's seven-day look-back period. During an interview on 10/7/2026 at 12:59 PM, the Director of Nursing (DON) confirmed item I5950 on Resident #4's MDS assessments with ARDs of 12/18/2025, 3/19/2026, and 6/17/2026 was incorrectly coded "No" and should have been coded "Yes." Record review of Resident #4's Admission Record revealed the resident was admitted to the facility on	F0641		

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F0641 SS = D	Continued from page 5 6/17/2019 with diagnoses that included unspecified psychosis not due to a substance or known physiological condition, major depressive disorder, recurrent, unspecified; unspecified mood (affective) disorder; and anxiety disorder, unspecified. Record review of Resident #4's MDS assessment with an ARD of 9/16/2026 revealed a Brief Interview for Mental Status (BIMS) summary score of 4 under Section C, indicating severe cognitive impairment. Resident #20 Record review of Resident #20's MDS assessment with an ARD of 7/7/2026 revealed item J0100B indicated the resident received as-needed (PRN) pain medication during the five-day look-back period of 7/3/2026 through 7/7/2026. However, items J0800A through J0800D, Staff Assessment for Pain, were marked "No," indicating none of the listed pain indicators were identified during that period. Record review of Resident #20's July 2026 MAR revealed the resident received PRN pain medication on 7/3/2026, 7/6/2026, and 7/7/2026. Documented pain scores were 5 on 7/3/2026 and 7/6/2026 and 3 on 7/7/2026, using a scale of 0 to 10. Record review of Resident #20's medication administration notes dated 7/3/2026 at 8:06 AM and 7/6/2026 at 7:15 AM revealed documentation of complaints of pain associated with administration of hydrocodone-acetaminophen 5-325 milligrams (mg), one tablet via percutaneous endoscopic gastrostomy (PEG) tube every six hours as needed for severe pain. A medication administration note dated 7/7/2026 at 10:40 PM also documented administration of the PRN (as needed) medication. During an interview on 10/7/2026 at 12:05 PM, the MDS Nurse stated she completed the staff assessment for pain based on the responses of the staff members she interviewed. She stated she did not remember whom she interviewed for Resident #20's assessment but acknowledged she apparently had not interviewed the nurse who administered the pain medication. During an interview on 10/7/2026 at 12:56 PM, the DON confirmed the MDS Nurse should have interviewed more than one nurse regarding Resident #20's pain, particularly because he received pain medication on three of the five days in the look-back period. She stated, "She could have called the nurse that administered the pain	F0641		

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F0641 SS = D	Continued from page 6 medication." Record review of Resident #20's Admission Record revealed the resident was admitted to the facility on 2/20/2025 with diagnoses that included aphasia following cerebral infarction; unspecified dementia, unspecified severity, with agitation; and cerebral infarction due to unspecified occlusion or stenosis of the basilar artery. Record review of Resident #20's MDS assessment with an ARD of 7/7/2026 revealed item C0100 indicated a BIMS interview should not be conducted because the resident was rarely or never understood.	F0641		
F0644 SS = D	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. This REQUIREMENT is NOT MET as evidenced by: Based on record review, interview, and facility policy review, the facility failed to refer a resident to the state-designated Mental Health Authority for Preadmission Screening and Resident Review (PASRR) Level II after receiving a newly identified serious mental illness diagnosis for one (1) of four (4) PASRR's reviewed. Resident #49 Findings include: Review of the facility policy titled "Admission Criteria" revealed the following under "Policy Interpretation and Implementation: … 9. All new	F0644		

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F0644 SS = D	Continued from page 7 admissions and readmissions are screened for mental disorders (MD), intellectual disabilities (ID) or related disorders (RD) per the Medicaid Pre-Admission Screening and Resident Review (PASARR) process…. (1) The admitting nurse notifies the social services department when a resident is identified as having a possible (or evident) MD, ID, or RD. (2) The social worker is responsible for making referrals to the appropriate state-designated authority..." Record review of the "Admission Record" revealed that Resident #49 was admitted to the facility on 10/08/22 with a diagnosis of Hypertensive Heart Disease with Heart Failure. Record review of Resident #49's PASRR dated 10/11/22 revealed active diagnoses of Major Depressive Disorder, Anxiety Disorder, Restless and Agitation. The screening did not indicate that the resident had a Serious Mental Illness (SMI). Record review of the "(Proper name of Inpatient Geriatric Behavioral Health) Aftercare/Discharge Continuing Care Plan" dated 12/04/23 revealed discharge diagnoses of Schizophrenia Disorder, Bipolar Type and Severe Generalized Anxiety Disorder. Record review of the "Admission Record" revealed that Resident #49 was readmitted to the facility on 12/04/23 with a new diagnosis of schizoaffective disorder and Bipolar Type was added on 12/05/23. Record review revealed no evidence that the facility referred Resident #49 to the state Mental Health Authority for PASRR after her readmission on 12/04/23 with a new diagnosis of Schizophrenia Disorder. Record review of the Significant Change Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 3/9/26 revealed under section A1500, "Is the resident currently considered by the state level II PASRR process to have serious mental illness and/or intellectual disability or a related condition?" No was indicated. During an interview on 10/06/26 at 3:31 PM, Social Services (SS) stated she was responsible for submitting PASRR referrals. She confirmed that Resident #49 received a new diagnosis of Schizophrenia following an inpatient geriatric behavioral health stay. She acknowledged that a new referral should have been sent to the state Mental Health Authority and that the purpose of the referral	F0644		

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F0644 SS = D	Continued from page 8 was to ensure the resident received all specialized services for her newly diagnosed mental illness. During an interview on 10/06/26 at 3:58 PM, the Administrator confirmed that a new PASRR referral should have been made when Resident #49 was readmitted to the facility with a new mental health diagnosis. Record review of the MDS with an ARD of 09/09/26 revealed a Brief Interview for Mental Status (BIMS) score of 14 in Section C, indicating that Resident #49 was cognitively intact.	F0644		
F0759 SS = D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is NOT MET as evidenced by: Based on observation, record review, interviews, and facility policy review, the facility failed to administer medications as ordered for two (2) of 28 medication administration opportunities observed, resulting in a medication error rate of 7.14%. Findings Include: Review of the facility policy titled “Medication Error Policy and Procedure” revealed the following under “Purpose: To provide safety to our residents...Policy: Any medication error shall be reported to the Director of Nurses and the resident physician upon noting of the error...” Resident #13 Review of Resident #13’s October 2026 Medication Administration Record (MAR) revealed an order dated 06/25/26, “Metoprolol Tartrate oral tablet 100 MG (milligrams) via (by) peg-tube (percutaneous endoscopic gastrostomy) two times a day for hypertension.” During a medication administration observation on 10/06/26 at 8:29 AM, Licensed Practical Nurse (LPN) #2 prepared and administered Resident #13’s morning medications separately through the	F0759		

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F0759 SS = D	Continued from page 9 gastrostomy tube but did not administer the ordered Metoprolol. During an interview on 10/06/26 at 10:03 AM, LPN #2 stated she thought she had administered the Metoprolol. After checking the medication blister card, she confirmed that she had omitted the medication in error. She stated that missing a dose could cause Resident #13's blood pressure to become high. During an interview on 10/07/26 at 8:25 AM, the Director of Nursing (DON) stated that she expected nurses to take their time and compare each medication with the MAR. After placing a medication in the medication cup, nurses were expected to select the prepared button on the MAR to indicate that the medication was in the cup and ready to be administered. The DON confirmed that the omission was a medication error. Review of the "Admission Record" revealed that Resident #13 was admitted to the facility on 06/24/26 with diagnoses that included Multiple Fractures of Ribs, Left Side, Essential (Primary) Hypertension and Gastrostomy Status. Review of the Minimum Data Set (MDS) assessment with an Assessment Reference Date (ARD) of 06/30/26 revealed a Brief Interview for Mental Status (BIMS) score of 6 in Section C, indicating that Resident #13 was severely cognitively impaired. Resident #49 Review of Resident #49's October 2026 MAR revealed an order dated 12/13/23, "Calcium Carbonate Vit (vitamin) D tablet 600-400 MG-Unit give 1 (one) tablet by mouth two times a day related to vitamin deficiency." During a medication administration observation on 10/06/26 at 7:54 AM, LPN #3 prepared and administered Resident #49's morning medications but did not administer the ordered calcium supplement. A record review comparison of the medications observed with the MAR revealed that the calcium supplement was documented as administered. An interview with LPN #3 was attempted on 10/06/26 at 9:36 AM. The DON stated that LPN #3 had left for the day and was unavailable for interview, but confirmed that the omission of the calcium tablet was a medication error.	F0759		

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F0759 SS = D	Continued from page 10 Review of the "Admission Record" revealed that Resident #49 was readmitted to the facility on 12/04/23 with diagnoses that included Schizoaffective Disorder, Bipolar Type and Hypertensive Heart Disease with Heart Failure. Review of the MDS assessment with an ARD of 09/09/26 revealed a BIMS score of 14 in Section C, indicating that Resident #49 was cognitively intact.	F0759		
F0880 SS = D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections;	F0880		

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(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
F0880 SS = D	Continued from page 11 (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, record review and facility policy review, the facility failed to ensure staff followed Enhanced Barrier Precautions (EBP) by wearing protective gowns during care for one (1) of three (3) residents observed receiving catheter care. (Resident #1) Findings include: A review of the facility's policy titled, "Isolation Policy and Procedure," with no revision date, under the section titled "Enhanced Barrier Precautions (EBP)," revealed, "2. PPE (Gloves and gown prior to the high-contact care activity) is to be utilized for these residents during high-contact resident activities...g. Device care or use…urinary catheter…" A record review of Resident #1's Order Summary	F0880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255111	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 10/07/2026

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F0880 SS = D	Continued from page 12 Report with active orders as of 10/06/2026 revealed Resident #1 had a suprapubic catheter. During an observation on 10/06/2026 at 3:10 PM, Licensed Practical Nurse (LPN)#1 and Certified Nursing Assistant (CNA) #1 were observed providing catheter care to Resident #1, who had a suprapubic catheter. Both staff members were observed leaning over the resident and touching him while providing catheter care without wearing protective gowns. During an interview on 10/06/2026 at 3:15 PM, LPN #1 and CNA #1, stated they were aware that gowns were required during catheter care but were nervous and forgot to put them on. Both staff members stated gowns were required to decrease the risk of spreading bacteria to other residents. During an interview on 10/07/2026 at 11:00 AM with the Administrator, he stated the facility's expectation was for staff to wear gowns when providing care to residents requiring Enhanced Barrier Precautions to prevent the spread of infections. Record review of Resident #1's Admission Record revealed the resident was admitted to the facility on 5/22/2026 with diagnoses that included Hemiplegia and Hemiparesis following Cerebral Infarction. Record review of Resident #1's Minimum Data Set (MDS) assessment with an Assessment Reference Date (ARD) of 8/26/2026 revealed Resident #1 had a Brief Interview for Mental Status (BIMS) score of 6 which indicated severe cognitive impairment.	F0880		