

MSDH - Health Facilities Licensure and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 59AL	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 01/30/2024
NAME OF PROVIDER OR SUPPLIER LONGWOOD COMM LIVING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 200 LONG STREET BOONEVILLE, MS 38829		
(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 (CI MS #23638) at the facility on 01/30/24. During the Survey, the SA investigated alleged abuse of a resident and determined that the facility was in compliance with the Minimal Standards of Operation for Institutions for the Aged or Infirm. There were no deficiencies cited. The census at the time of the complaint survey was 40 and they were licensed for 64 beds.	M 000		

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

TITLE

(X6) DATE

Electronically Signed

02/08/24