

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/16/2024  
FORM APPROVED  
OMB NO. 0938-0391

|                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                            |                                                                                                                          |                            |                                                        |
|------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|----------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>255264</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____                                                     |                            | (X3) DATE SURVEY<br>COMPLETED<br><br><b>08/22/2024</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>LONGWOOD COMM LIVING CENTER</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                            | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>200 LONG STREET<br/>BOONEVILLE, MS 38829</b>                                 |                            |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                               | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | ID<br>PREFIX<br>TAG                                                        | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETION<br>DATE |                                                        |
| F 000                                                                  | INITIAL COMMENTS<br><br>The State Agency (SA) conducted an annual recertification survey at the facility from 8/20/24 through 8/22/24. During the survey, the SA determined that the facility was not in compliance with Medicare and Medicaid requirements of participation and cited F578, F584, F656, and F699.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | F 000                                                                      |                                                                                                                          |                            |                                                        |
| F 578<br>SS=D                                                          | The census at the time of the survey was 44 with a bed capacity of 64 beds.<br>Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir<br>CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v)<br><br>§483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.<br><br>§483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate.<br><br>§483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives).<br>(i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive.<br>(ii) This includes a written description of the facility's policies to implement advance directives and applicable State law.<br>(iii) Facilities are permitted to contract with other entities to furnish this information but are still | F 578                                                                      |                                                                                                                          | 9/11/24                    |                                                        |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

09/09/2024

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 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.

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/16/2024  
FORM APPROVED  
OMB NO. 0938-0391

|                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                            |                                                        |
|------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>255264</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                            | (X3) DATE SURVEY<br>COMPLETED<br><br><b>08/22/2024</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>LONGWOOD COMM LIVING CENTER</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                            | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>200 LONG STREET<br/>BOONEVILLE, MS 38829</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                            |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                               | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | ID<br>PREFIX<br>TAG                                                        | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | (X5)<br>COMPLETION<br>DATE |                                                        |
| F 578                                                                  | <p>Continued From page 1</p> <p>legally responsible for ensuring that the requirements of this section are met.</p> <p>(iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law.</p> <p>(v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on staff interview, record review, and facility policy review, the facility failed to ensure accuracy of a code status based on the Power of Attorney for one (1) of 14 residents sampled. Resident #19</p> <p>Findings include:</p> <p>Record review of facility policy titled, "Advanced Directives" reviewed 11/2022, revealed, "Policy Statement: The resident has the right to formulate an advance directive, including the right to accept or refuse medical or surgical treatment. Advance directives are honored in accordance with state law and facility policy ...If the Resident has an Advance Directive: 1. If the resident or the residents representative has executed one or more advance directive(s), or executes one upon admission, copies of these documents are obtained and maintained in the same section of the residents medical record and are readily retrievable by any facility staff. 2. The director of</p> | F 578                                                                      | <p>1. After consulting with Resident # 19, the Advanced Directive was clarified and corrected by the Power of Attorney on 8/22/2024. A 100% audit of all charts was conducted and completed on 9/5/24 by the Social Services Director with no additional issues were found.</p> <p>2. All residents have the potential to be affected.</p> <p>3. On 8/22/2024, a one-on-one in-service was conducted for the Social Services Director and the Business Office Manager by the Administrator to make sure that the Advance Directive matches the residents' wishes, the Doctor's orders, and the order is properly entered in the Electronic Medical Record.</p> <p>4. New admissions will be audited weekly for the Advanced Directives; Doctor's</p> |                            |                                                        |

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/16/2024  
FORM APPROVED  
OMB NO. 0938-0391

|                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                            |                                                        |
|------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>255264</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                            | (X3) DATE SURVEY<br>COMPLETED<br><br><b>08/22/2024</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>LONGWOOD COMM LIVING CENTER</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                            | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>200 LONG STREET<br/>BOONEVILLE, MS 38829</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                            |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                               | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | ID<br>PREFIX<br>TAG                                                        | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | (X5)<br>COMPLETION<br>DATE |                                                        |
| F 578                                                                  | <p>Continued From page 2</p> <p>nursing services (DON) or designee notifies the attending physician of advance directive (or changes in advance directives) so that appropriate orders can be documented in the residents medical record and plan of care ..."</p> <p>Record review of Resident #19's "Durable Power of Attorney for Health Care" signed and dated by the resident on 2/20/24, revealed, "Special Instructions: Do not resuscitate after one (1) hour of trying. No life support machine(s) in any town city, or state".</p> <p>Record review of electronic physician's order dated 4/1/24, revealed an order for DNR (Do Not Resuscitate)". Record review of "Order Details" dated 4/124 revealed a physician's telephone order for a DNR, which was signed by the physician.</p> <p>Record review of "Code Status" form for Resident #19 signed by a family member and not the Resident's Representative on admission 4/1/24, revealed "Do Not Attempt Resuscitation (DNR)".</p> <p>During an interview on 8/22/24 at 9:15 AM, the Administrator revealed the special instructions on Resident #19's Power of Attorney document for "Do not resuscitate after one (1) hour of trying. No life support machine(s) in any town city, or state" would indicate the Cardio-Pulmonary Resuscitation (CPR) should be initiated. She confirmed the physician's orders and code status form did not reflect the wishes conveyed in Resident #19's "Durable Power of Attorney for Health Care" document concerning his end-of-life care. She acknowledged this could lead to a resident not receiving the end-of-life care desired. She confirmed that record accuracy of end-of-life</p> | F 578                                                                      | <p>orders and electronic medical records by the Medical Records Specialist or the Administrator for compliance of F578 beginning 8/22/24 x 3 months. The Social Services Director will review advanced directives with resident and/or resident representative during resident's quarterly assessment period for all residents beginning 8/22/24 and ongoing to ensure advanced directives wishes are still being followed and will update as needed. The Administrator will report the results of the audit to Quality Assurance Performance Improvement Committee (QAPI) monthly x three months starting 9/11/24 and as needed for review and/or revision.</p> |                            |                                                        |

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/16/2024  
FORM APPROVED  
OMB NO. 0938-0391

|                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                            |                                                                                                                          |  |                                                        |
|------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>255264</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____                                                     |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>08/22/2024</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>LONGWOOD COMM LIVING CENTER</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                            | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>200 LONG STREET<br/>BOONEVILLE, MS 38829</b>                                 |  |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                               | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | ID<br>PREFIX<br>TAG                                                        | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETION<br>DATE                             |
| F 578                                                                  | Continued From page 3<br><br>care was necessary to ensure the information concerning end of life care was reflective of the resident's wishes and the facility failed to accurately indicate Resident #19's choice for end-of-life care.<br><br>Record review of Resident #19's "Admission Record," revealed the facility admitted the resident on 4/1/24. Diagnoses included Dysphagia following cerebral infarction and Chronic kidney disease.<br><br>Record review of Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 7/3/24 revealed a Brief Interview for Mental Status (BIMS) of 12 which indicated the resident was moderately impaired cognitively.                                                                                                                                  | F 578                                                                      |                                                                                                                          |  |                                                        |
| F 584<br>SS=D                                                          | Safe/Clean/Comfortable/Homelike Environment<br>CFR(s): 483.10(i)(1)-(7)<br><br>§483.10(i) Safe Environment.<br>The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.<br><br>The facility must provide-<br>§483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible.<br>(i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk.<br>(ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. | F 584                                                                      |                                                                                                                          |  | 9/11/24                                                |

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/16/2024  
FORM APPROVED  
OMB NO. 0938-0391

|                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                            |                                                        |
|------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>255264</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____                                                                                                                                                                                                                                                                                                                                                                                                                                             |                            | (X3) DATE SURVEY<br>COMPLETED<br><br><b>08/22/2024</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>LONGWOOD COMM LIVING CENTER</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                            | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>200 LONG STREET<br/>BOONEVILLE, MS 38829</b>                                                                                                                                                                                                                                                                                                                                                                                                                         |                            |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                               | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | ID<br>PREFIX<br>TAG                                                        | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY)                                                                                                                                                                                                                                                                                                                                                                                         | (X5)<br>COMPLETION<br>DATE |                                                        |
| F 584                                                                  | <p>Continued From page 4</p> <p>§483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior;</p> <p>§483.10(i)(3) Clean bed and bath linens that are in good condition;</p> <p>§483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv);</p> <p>§483.10(i)(5) Adequate and comfortable lighting levels in all areas;</p> <p>§483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and</p> <p>§483.10(i)(7) For the maintenance of comfortable sound levels.</p> <p>This REQUIREMENT is not met as evidenced by:<br/>Based on observation, resident and staff interview, and facility policy review, the facility failed to provide a safe environment as evidenced by an overbed table with exposed jagged edges for one (1) of 44 resident's observed. Resident #37</p> <p>Findings Included:</p> <p>Record review of the facility policy titled, "Maintenance Service" with revision date of December 2009, revealed, "The maintenance department is responsible for maintaining the buildings, grounds, and equipment in a safe and operable manner at all times..."</p> | F 584                                                                      | <p>1. On 8/21/2024 Resident # 37's overbed table was immediately discarded and replaced with a new overbed table by the Maintenance Director.</p> <p>2. This alleged deficient practice has the potential to affect all residents.</p> <p>3. On 8/21/2024, One on One Inservice was conducted with the Director of Maintenance by the Administrator to ensure that furniture in residents' rooms is in working order.</p> <p>4. The Director of Maintenance will do a weekly check of all resident rooms and</p> |                            |                                                        |

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/16/2024  
FORM APPROVED  
OMB NO. 0938-0391

|                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                             |                            |                                                        |
|------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>255264</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____                                                                                                                                                                                                                                                                                                                                                        |                            | (X3) DATE SURVEY<br>COMPLETED<br><br><b>08/22/2024</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>LONGWOOD COMM LIVING CENTER</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                            | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>200 LONG STREET<br/>BOONEVILLE, MS 38829</b>                                                                                                                                                                                                                                                                                                                                    |                            |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                               | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | ID<br>PREFIX<br>TAG                                                        | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY)                                                                                                                                                                                                                                                                                                    | (X5)<br>COMPLETION<br>DATE |                                                        |
| F 584                                                                  | <p>Continued From page 5</p> <p>On 08/21/24 at 9:10 AM, an observation and interview revealed Resident #37 lying in bed with her over bed table positioned beside her on the right side of the bed. The plastic protective border was missing from all four sides of the over bed table and there were rough, jagged areas exposed. Resident #37 revealed that the rough edges on her over bed table could scratch her and if she rubbed up against the edges, she stated, "It might bruise me." Resident #37 also revealed that her skin was thin and would easily tear.</p> <p>On 08/21/24 at 2:00 PM, an interview with Director of Nursing (DON) confirmed that Resident #37's over bed table had rough outer edges exposed and that the protective border was missing from all four sides. She revealed that the rough edges on the over bed table could cause skin tears or bruising. She revealed that this should have already been noticed and replaced.</p> <p>Record review of Resident #37's "Admission Record" revealed that she admitted on 05/03/2024 and had diagnoses that included Unspecified Dementia, Anxiety, and Muscle Weakness.</p> <p>Record review of Resident #37's Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 05/09/2024 under Section C revealed a Brief Interview for Mental Status (BIMS) score of 10 which indicated that she had moderate cognitive deficits.</p> | F 584                                                                      | <p>report on any furniture that should be replaced or repaired beginning 8/21/24 x 3 months. The report will be given to the Administrator and the Administrator will submit the order request for needed items. The Administrator will report the results of the audit to Quality Assurance Performance Improvement Committee (QAPI) monthly x three months starting 9/11/24 and as needed for review and/or revision.</p> |                            |                                                        |
| F 656<br>SS=D                                                          | <p>Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3)</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | F 656                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                             | 9/11/24                    |                                                        |

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/16/2024  
FORM APPROVED  
OMB NO. 0938-0391

|                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                            |                                                                                                                          |                            |                                                        |
|------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|----------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>255264</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____                                                     |                            | (X3) DATE SURVEY<br>COMPLETED<br><br><b>08/22/2024</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>LONGWOOD COMM LIVING CENTER</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                            | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>200 LONG STREET<br/>BOONEVILLE, MS 38829</b>                                 |                            |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                               | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | ID<br>PREFIX<br>TAG                                                        | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETION<br>DATE |                                                        |
| F 656                                                                  | Continued From page 6<br>§483.21(b) Comprehensive Care Plans<br>§483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following -<br>(i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and<br>(ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).<br>(iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.<br>(iv) In consultation with the resident and the resident's representative(s)-<br>(A) The resident's goals for admission and desired outcomes.<br>(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.<br>(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the | F 656                                                                      |                                                                                                                          |                            |                                                        |

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/16/2024  
FORM APPROVED  
OMB NO. 0938-0391

|                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                            |                                                        |
|------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>255264</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                            | (X3) DATE SURVEY<br>COMPLETED<br><br><b>08/22/2024</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>LONGWOOD COMM LIVING CENTER</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                            | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>200 LONG STREET<br/>BOONEVILLE, MS 38829</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                            |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                               | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | ID<br>PREFIX<br>TAG                                                        | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | (X5)<br>COMPLETION<br>DATE |                                                        |
| F 656                                                                  | <p>Continued From page 7</p> <p>requirements set forth in paragraph (c) of this section.</p> <p>§483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-</p> <p>(iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by:</p> <p>Based on staff interviews, record review, and facility policy review, the facility failed to develop a person-centered care plan for residents with a diagnosis of Post-Traumatic Stress Disorder (PTSD) for two (2) of the 14 resident care plans reviewed. Resident #11 and Resident #37.</p> <p>Findings included:</p> <p>Review of the facility policy titled, "Care Plans, Comprehensive Person-Centered" undated revealed, "A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. ...8. Services provided for or arranged by the facility and outlined in the comprehensive care plan are: a. provided by qualified persons; b. culturally competent; and c. trauma-informed."</p> <p>Resident #11</p> <p>Record review of Resident #11's care plans revealed the resident did not have a care plan regarding PTSD.</p> <p>During an interview on 8/20/24 at 1:16 PM, Resident #11 revealed she does have PTSD because she had a traumatic event happen to her as a child.</p> | F 656                                                                      | <p>1. On 8/21/2024, the MDS nurse updated the Care Plan for Resident #11 and Resident #37 regarding the Post Traumatic Stress Disorder diagnosis.</p> <p>2. All Residents with the diagnosis of Post Traumatic Stress Disorder have the potential to be affected. One on one Inservice was conducted by the Administrator with the Minimum Data Set Nurse on 8/21/24 regarding comprehensive care plans and Post Traumatic Stress Disorder care plans.</p> <p>3. All residents with this diagnosis were audited by the Minimum Data Set Nurse on 8/21/24 and care plans were added if needed.</p> <p>4. Diagnosis Audits will be completed monthly by Medical Records Nurse or Director of Nursing beginning 8/21/24 x 3 months. The Administrator will report the results of the audit to Quality Assurance Performance Improvement Committee (QAPI) monthly x three months starting 9/11/24 and as needed for review and/or revision.</p> |                            |                                                        |

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/16/2024  
FORM APPROVED  
OMB NO. 0938-0391

|                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                            |                                                                                                                          |  |                                                        |
|------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>255264</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____                                                     |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>08/22/2024</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>LONGWOOD COMM LIVING CENTER</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                            | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>200 LONG STREET<br/>BOONEVILLE, MS 38829</b>                                 |  |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                               | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | ID<br>PREFIX<br>TAG                                                        | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETION<br>DATE                             |
| F 656                                                                  | <p>Continued From page 8</p> <p>An interview on 8/21/24 at 3:01 PM, Registered Nurse (RN)/ Minimum Data Set (MDS) Coordinator, confirmed Resident #11 does have a diagnosis of PTSD. However, she does not have a comprehensive care plan addressing this diagnosis. She revealed it was not developed because it was missed in error. She revealed that the care plan is developed so the staff knows how to care for each resident and Resident #11 should already have a care plan already in place for her PTSD.</p> <p>During an interview on 8/22/24 at 11:25 AM, the Director of Nurses (DON) confirmed Resident #11 has a diagnosis of PTSD. However, a trauma-informed care plan was not developed and was missed. She revealed it is very important that anyone with a PTSD diagnosis has a care plan addressing it.</p> <p>Record review of Resident #11's "Admission Record" revealed the resident was admitted to the facility on 03/10/2020 with diagnoses that included Type 2 Diabetes Mellitus, Peripheral Vascular Disease, and a PTSD diagnosis which was added with an onset date of 10/27/2023.</p> <p>Record review of Resident #11's Minimum Data Set (MDS) with an Assessment Reference Date of 07/10/24, revealed in Section I that the resident had a diagnosis of PTSD and in Section C a Brief Interview Mental Status (BIMS) score of 15, which indicated the resident is cognitively intact. Resident #37</p> <p>Record review of Resident #37's Care Plans revealed there was not a care plan in place to address PTSD that included triggers or</p> | F 656                                                                      |                                                                                                                          |  |                                                        |

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/16/2024  
FORM APPROVED  
OMB NO. 0938-0391

|                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                            |                                                                                                                          |                            |                                                        |
|------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|----------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>255264</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____                                                     |                            | (X3) DATE SURVEY<br>COMPLETED<br><br><b>08/22/2024</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>LONGWOOD COMM LIVING CENTER</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                            | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>200 LONG STREET<br/>BOONEVILLE, MS 38829</b>                                 |                            |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                               | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | ID<br>PREFIX<br>TAG                                                        | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETION<br>DATE |                                                        |
| F 656                                                                  | <p>Continued From page 9 interventions.</p> <p>On 08/21/24 at 11:05 AM, an observation and interview with Resident #37 revealed she was sitting up in her wheelchair in her room. Resident #37 revealed that she had a three month old baby to die many years ago and also had an adult son who had passed away in his sleep about 20 years ago and this still bothered her. Resident #37 revealed that she often had nightmares, cried out in her sleep and had done this for a long time and didn't know what caused it. She also revealed that she worried about all of her kids and grandkids because she had lost her own children.</p> <p>On 08/21/24 at 3:05 PM, an interview with RN/MDS Coordinator confirmed the resident had a diagnosis of PTSD and did not have a comprehensive care plan addressing this diagnosis. She revealed that the care plan was developed so the staff knew how to take care of the individualized needs of the resident. The RN/MDS Coordinator confirmed that Resident #37's care plan for her PTSD had not been developed and that it should have been.</p> <p>On 08/22/24 at 11:45 AM, an interview with the DON revealed that the RN/MDS Coordinator was responsible for care planning the needs of each resident and that Resident #37's Trauma Informed Care Assessment should have been completed to help identify any possible triggers and these triggers should be included in her care plan.</p> <p>Record review of Resident #37's "Psych Eval (Evaluation)" dated June 20, 2024, revealed "Recommendations: Add ...Post traumatic stress disorder, chronic to diagnoses."</p> | F 656                                                                      |                                                                                                                          |                            |                                                        |

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/16/2024  
FORM APPROVED  
OMB NO. 0938-0391

|                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                            |                                                                                                                                                                                                                                                                                                                                                                                           |                            |                                                        |
|------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>255264</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____                                                                                                                                                                                                                                                                                                                      |                            | (X3) DATE SURVEY<br>COMPLETED<br><br><b>08/22/2024</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>LONGWOOD COMM LIVING CENTER</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                            | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>200 LONG STREET<br/>BOONEVILLE, MS 38829</b>                                                                                                                                                                                                                                                                                                  |                            |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                               | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | ID<br>PREFIX<br>TAG                                                        | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY)                                                                                                                                                                                                                                                                  | (X5)<br>COMPLETION<br>DATE |                                                        |
| F 656                                                                  | Continued From page 10<br><br>Record review Resident #37's "Admission Record" revealed that she was admitted on 05/03/24 with diagnoses that included Unspecified Dementia with other behavioral disturbance, Anxiety Disorder and Hallucinations. The diagnosis of Post-Traumatic Stress Disorder, Chronic was added on 06/24/24.<br><br>Record review of Resident #37's MDS with ARD of 05/09/24 under Section C revealed a BIMS score of 10 which indicated that she had moderate cognitive deficits.                                                                                                                                                                                                                                                                                                                                                                                            | F 656                                                                      |                                                                                                                                                                                                                                                                                                                                                                                           |                            |                                                        |
| F 699<br>SS=D                                                          | Trauma Informed Care<br>CFR(s): 483.25(m)<br><br>§483.25(m) Trauma-informed care<br>The facility must ensure that residents who are trauma survivors receive culturally competent, trauma-informed care in accordance with professional standards of practice and accounting for residents' experiences and preferences in order to eliminate or mitigate triggers that may cause re-traumatization of the resident. This REQUIREMENT is not met as evidenced by:<br>Based on resident and staff interviews, record review, and facility policy review the facility failed to complete a Trauma Informed Care Assessment for a resident with Post Traumatic Stress Disorder (PTSD) diagnosis for one (1) of two (2) residents reviewed for PTSD. Resident #37.<br><br>Findings Included:<br><br>Record review of the undated facility policy titled "Trauma Informed Care" undated, revealed "It is | F 699                                                                      | 1. All residents with the diagnosis of Post Traumatic Stress Disorder were audited by Minimum Data Set Nurse on 8/21/24 and the Trauma informed care form was completed if needed.<br><br>2. All residents with the diagnosis of Post Traumatic Stress Disorder or any other diagnosis that would result in the trauma informed care from to be needed have the potential to be affected. | 9/11/24                    |                                                        |

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/16/2024  
FORM APPROVED  
OMB NO. 0938-0391

|                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                            |                                                        |
|------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>255264</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                            | (X3) DATE SURVEY<br>COMPLETED<br><br><b>08/22/2024</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>LONGWOOD COMM LIVING CENTER</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                            | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>200 LONG STREET<br/>BOONEVILLE, MS 38829</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                            |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                               | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | ID<br>PREFIX<br>TAG                                                        | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | (X5)<br>COMPLETION<br>DATE |                                                        |
| F 699                                                                  | <p>Continued From page 11</p> <p>the policy of this facility to provide culturally competent, trauma-informed care to residents who are trauma survivors in accordance with professional standard of practice."</p> <p>On 08/21/24 at 11:05 AM, an observation and interview with Resident #37 revealed her sitting up in her wheelchair in her room. Resident #37 revealed that she had a three-month- old baby who died many years ago and also had an adult son who was "found dead in his bed" about 20 years ago and this caused her to worry a lot about her kids and grandkids. Resident #37 revealed that she often had nightmares and cried out in her sleep at night but didn't know what caused it.</p> <p>On 08/21/24 PM at 3:10 PM, an interview with Social Services revealed that she was responsible for completing the Trauma Informed Care Assessment on admission and any time there was a change in condition or a new diagnosis of PTSD. She revealed that she was not aware of Resident #37's PTSD diagnosis and confirmed that with this new diagnosis, she should have completed a Trauma Informed Care Assessment. Social Services revealed that they had a Care Plan Meeting with Resident #37 and her family and they reported that she yelled out at night during her sleep, that nothing seemed to trigger it, and that she had been doing it for a long time. She revealed that the family also denied any past traumatic events other than the death of two children that happened many years ago. Social Services revealed that Resident #37 was diagnosed with PTSD on 06/24/2024 and it should have triggered them to do another Trauma Informed Care Assessment but they had missed it somehow.</p> | F 699                                                                      | <p>3. One on one Inservice was conducted/ by the Administrator with the Director of Social Services and the Medical Records Specialist on 8/21/24 regarding the requirement to complete a Trauma Informed Care Assessment for a resident with Post Traumatic Stress Disorder diagnosis.</p> <p>4. Beginning 8/21/24, Director of Social Services will review all new admission diagnoses or any current resident with newly diagnosed Post Traumatic Stress Disorder weekly and will complete a Trauma Informed Care Assessment if needed x 3 months. The Social Services Director will report the results of the audit to Quality Assurance Performance Improvement Committee (QAPI) monthly x three months starting 9/11/24 and as needed for review and/or revision.</p> |                            |                                                        |

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/16/2024  
FORM APPROVED  
OMB NO. 0938-0391

|                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                            |                                                                                                                          |  |                                                        |
|------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>255264</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____                                                     |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>08/22/2024</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>LONGWOOD COMM LIVING CENTER</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                            | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>200 LONG STREET<br/>BOONEVILLE, MS 38829</b>                                 |  |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                               | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | ID<br>PREFIX<br>TAG                                                        | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETION<br>DATE                             |
| F 699                                                                  | <p>Continued From page 12</p> <p>On 08/22/24 at 11:45 AM, an interview with Director of Nursing (DON) revealed that Resident #37 admitted to the facility on 05/03/24 for therapy services and was told by her family on 06/20/24 that she had to remain long-term in the facility and could not return to her home. The DON revealed that Resident #37 was upset and very tearful about having to stay long term. The DON revealed that they had not reported any other traumatic events in Resident #37's past other than her losing two of her children. The DON confirmed that they had discussed with the family about her crying out in her sleep and her family "brushed it off" and said that she cried out in her sleep all the time at home. She revealed that a psychiatric Nurse Practitioner evaluated Resident #37 and the new diagnosis of PTSD was added on 06/24/24. The DON revealed that a Trauma Informed Care Assessment should have been completed with this new diagnosis and she didn't know why it wasn't done.</p> <p>Record review of Resident #37's "Psych Eval (Evaluation)" dated June 20, 2024, revealed "Recommendations: Add ...Post traumatic stress disorder, chronic to diagnoses."</p> <p>Record review Resident #37's "Admission Record" revealed an admission date of 05/03/24 with diagnoses that included Unspecified Dementia with other behavioral disturbance, Anxiety Disorder and Hallucinations. The diagnosis of Post-Traumatic Stress Disorder, Chronic was added on 06/24/24.</p> <p>Record review of Resident #37's Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 05/09/24 under Section C revealed a</p> | F 699                                                                      |                                                                                                                          |  |                                                        |

|                                                                        |                                                                                                                                          |                                                                            |                                                                                                                          |  |                                                        |
|------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                    |                                                                                                                                          | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>255264</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____                                                     |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>08/22/2024</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>LONGWOOD COMM LIVING CENTER</b> |                                                                                                                                          |                                                                            | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>200 LONG STREET</b><br><b>BOONEVILLE, MS 38829</b>                           |  |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                               | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)             | ID<br>PREFIX<br>TAG                                                        | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETION<br>DATE                             |
| F 699                                                                  | Continued From page 13<br>Brief Interview for Mental Status (BIMS) Score of 10 which indicated that she had moderate cognitive deficits. | F 699                                                                      |                                                                                                                          |  |                                                        |