

MSDH - Health Facilities Licensure and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 59AL	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 12/14/2021
NAME OF PROVIDER OR SUPPLIER LONGWOOD COMM LIVING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 200 LONG STREET BOONEVILLE, MS 38829		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
M 000	Initial Comments The State Agency (SA) conducted a complaint survey, MS #18352, and MS #18356 at the facility from 12/13/2021 to 12/14/2021. The SA determined that the facility followed the requirements for The Aged and Infirmed. The SA was unable to substantiate CI MS#18352 related to dietary services, and inappropriate feeding assist, and CI MS #18356 related to Quality of care /treatment with subcategories of resident not groomed, client services not performed, care/services not received per physician orders, Physical environment, Misappropriation of property and not sufficient supplies cited no deficiencies. The facility was licensed for 63 beds and had a census of 47 at the time of the survey.	M 000		

Mississippi State Department of Health

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

TITLE

(X6) DATE

Electronically Signed

01/06/22