

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 03/31/2021
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 investigating MS 00017219 on 3/30/2021 - 3/31/2021. Concerns identified in the complaint were related to quality of care/treatment - residents not groomed adequately, resident neglect, quality of care/treatment - residents' medications not given according to the physician's instructions, and rehabilitation services. These concerns were not substantiated and no deficiencies were cited. During the survey the SA determined the facility was in substantial compliance with requirements for the Aged and Infirm. The facility had a census of 48 at the time of the complaint survey, with a license for 64 bed capacity.	M 000		

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

TITLE

(X6) DATE