MSDH - Health Facilities Licensure and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	59AL	A. BUILDING: _____ B. WING _____	R-C 09/20/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LONGWOOD COMM LIVING CENTER	200 LONG STREET/P. O. BOX 326 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 A Desk Review was completed on 09/20/20 for all previous deficiencies cited on the 02/19/20 Complaint Investigation survey CI MS# 16486. All deficiencies have been corrected, and no new noncompliance was found. The facility is in substantial compliance with Medicare and Medicaid Participation requirements as of 04/01/20.	{M 000}		

Mississippi State Department of Health

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