

MSDH - Health Facilities Licensure and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 59AL	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 01/12/2023
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 investigation (CI) survey, MS00020256, on 01/12/2023. The SA did not substantiate the complaint for quality of care related to facility staffing. During the survey the SA determined the facility was in compliance with the Minimum Standards of Operation for Institutions for the Aged or Infirm, state licensure requirements, with no deficiencies were cited. The facility held a license for 64 beds and had a census of 41 during the time of survey.	M 000		

Mississippi State Department of Health

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

TITLE

(X6) DATE

Electronically Signed

01/23/23