

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255264		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/25/2026	
NAME OF PROVIDER OR SUPPLIER LONGWOOD COMMUNITY LIVING CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 200 LONG STREET , BOONEVILLE, Mississippi, 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) COMPLETION DATE
F0000	INITIAL COMMENTS The State Agency (SA) conducted a Complaint Investigation (CI MS #3131625), at the facility from 8/24/2026 through 8/25/2026. CI MS #3131625 was investigated for falls, accuracy of records, medication administration, and behaviors. During the survey, the SA determined the facility was not in compliance with the requirements of participation in Medicare and Medicaid and cited F842. The facility held a license for 64 beds, with a census of 51.			F0000			
F0842 SS = D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5),483.70(h)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(h) Medical records. §483.70(h)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(h)(2) The facility must keep confidential all information contained in the resident's records,			F0842			

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 reverse for further 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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE		TITLE	(X6) DATE
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F0842 SS = D	Continued from page 1 regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(h)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(h)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(h)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic	F0842					

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F0842 SS = D	Continued from page 2 services reports as required under §483.50. This REQUIREMENT is NOT MET as evidenced by: Based on staff interviews, record review, and facility policy review, the facility failed to maintain complete, accurately documented clinical records for one (1) of eight (8) residents reviewed for clinical record accuracy. (Resident #1). Findings Include: Record review of facility policy titled "Charting and Documentation Policy and Procedure" revealed, "The purpose of Charting and Documentation is to provide the following; A complete account to the resident's care, treatment, response to the care, signs, symptoms, and progress of resident care..." Record review of "Neurological Checks" revealed neurological assessments documented for Resident #1 as obtained on 8/2/2026 at 8:15 AM, 12:15 PM, and 4:15 PM. The assessments included documentation of the resident's level of consciousness, pupil response, motor function, pain response, blood pressure, temperature, pulse, respirations, and observations. The neurological assessments were electronically signed by the Minimum Data Set (MDS) Coordinator on 8/12/2026. Record review of "Employee Timecards" revealed the MDS Coordinator's documented start time on 8/2/2026 was 6:57 PM, with a stop time of 7:29 PM. During an interview on 8/25/2026 at 2:00 PM, the MDS Coordinator stated that she personally performed neurological checks on Resident #1 on 8/2/2026 at 8:15 AM, 12:15 PM, and 4:15 PM. When questioned regarding her employee timecard, which documented a start time of 6:57 PM and a stop time of 7:29 PM on 8/2/2026, the MDS Coordinator stated that she had come to the facility that morning because she anticipated she would have to work the 2:00 PM to 10:00 PM shift again. She stated that she performed the neurological checks while working off the clock. During an interview on 8/25/2026 at 1:55 PM, Registered Nurse (RN) #1 stated the MDS Coordinator was not present when she arrived at work on the morning of 8/2/2026 and was not at the facility at any time during the day. She stated the MDS Coordinator came to the facility later that evening following an incident involving a disgruntled employee who was sent home.	F0842			

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F0842 SS = D	Continued from page 3 During an interview on 8/25/2026 at 2:07 PM, the Administrator stated he arrived at the facility at approximately 5:30 PM on 8/2/2026 to counsel an employee. He stated the MDS Coordinator was not present at the facility when he arrived. The Administrator stated he called the MDS Coordinator and asked her to come to the facility to cover the medication cart after the employee was sent home. He stated the MDS Coordinator arrived later that evening and covered the medication cart for approximately 30 minutes until the night-shift nurse arrived early and relieved her. When informed that the MDS Coordinator stated she had been at the facility earlier that day and had performed the neurological checks while working off the clock, the Administrator stated that, to his knowledge, the MDS Coordinator had not been at the facility during the day. He stated staff should not work off the clock. When the MDS Coordinator's timecard and the documented times of the neurological checks were reviewed with him, the Administrator acknowledged the importance of ensuring resident clinical documentation is accurate. Record review of "Admission Record" revealed Resident #1 was admitted to facility on 7/6/2026 with diagnoses that included Volvulus and Dementia in Other Diseases Classified Elsewhere, Severe, with Mood Disturbance.			F0842			