STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255264	A. Building B. Wing	12/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Longwood Community Living Center	200 Long Street Booneville, MS 38829

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

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 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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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interviews, and record review, the facility failed to ensure adequate supervision for (1) one of (3) three residents reviewed for behaviors. Resident #1. Findings include:Record review of the admission Record revealed Resident #1 was admitted on [DATE] with diagnoses of unspecified dementia with behavioral disturbance, bipolar disorder, and Alzheimer's disease.Record review of the Brief Interview for Mental Status (BIMS) dated 10/29/25 revealed a score of 11, indicating Resident #1 was moderately cognitively impaired.Record review of progress notes for Resident #1 dated 11/5/25 through 12/11/25 revealed six documented episodes of inappropriate behaviors.Record review of Resident #1's Order Recap Report revealed on 12/4/25 oxcarbazepine 150 mg (milligrams) one tablet twice daily for mood was increased to 300 mg twice daily due to continued inappropriate behaviors.Record review of the December 2025 Medication Administration Record for Resident #1 revealed no documentation of monitoring or supervision related to the resident's increased behaviors.Record review of an incident report dated 12/11/25 at 5:02 PM revealed Resident #1 was observed attempting to rub Resident #2's leg while stating, Gimme some of that right there. The Business Office Manager (BOM) and Activity Certified Nurse Assistant (CNA) #1 immediately intervened. Resident #1 was taken to his room and monitored until he was transferred by ambulance to behavioral health for evaluation.Record review of the admission Record revealed Resident #2 was admitted on [DATE] with a diagnosis of unspecified dementia.Record review of the BIMS dated 10/22/25 revealed a score of 3, indicating Resident #2 was severely cognitively impaired and unable to protect herself from unsafe interactions.Review of records and staff interviews revealed the facility failed to implement increased supervision or monitoring for Resident #1 despite documented escalating behaviors, placing Resident #2 at risk for avoidable harm.An interview with CNA #2 on 12/23/25 at 10:00 AM revealed she observed Resident #1 touch Resident #2's upper leg but did not hear him say anything. She stated Resident #1 has a history of making vulgar comments to staff.An interview with the BOM on 12/23/25 at 10:15 AM revealed she observed Resident #1 sitting next to Resident #2, leaning toward her and talking, but did not see him do anything inappropriate. An interview with Activity CNA #1 on 12/23/25 at 10:20 AM revealed she observed Resident #1 attempt to move his hand upward while touching Resident #2's upper leg and heard him say, Gimme some of that right there. She stated staff immediately intervened and Resident #1 was moved away by the Director of Nursing (DON).An interview with Licensed Practical Nurse (LPN) #1 on 12/23/25 at 11:00 AM revealed Resident #1 is known to make sexual comments to staff and visitors and has been sent out previously for psychiatric services. She confirmed that they had monitored the resident for medication changes and he had been evaluated by psychiatric services but confirmed that they should have had increased monitoring in place for Resident #1's behaviors.An interview with CNA #3 on 12/23/25 at 11:35 AM revealed she had heard Resident #1 make sexual comments. She stated she was unaware of any increased monitoring in place related to those behaviors.An interview with the DON on 12/23/25 at 11:45 AM revealed after review of Resident #1's record she was unable to find documentation indicating increased supervision and monitoring for the resident's sexual behaviors. She also confirmed that they had implemented medication changes and he had been evaluated by psychiatric services but confirmed that they should have had increased supervision and monitoring in place for Resident #1's behaviors.An interview with the Administrator on 12/23/25 at 11:50 AM revealed Resident #1 had previously been sent out for psychiatric services related to inappropriate comments and had multiple medication changes. She confirmed that the facility did not have a policy for supervision but that with the documented increase in behaviors the facility should have implemented increased monitoring to reduce the risk of an incident.