MISSISSIPPI STATE DEPARTMENT OF HEALTH

ELECTRONIC MAIL

March 7, 2019

Jonathan Allen, Administrator
Ms State Veterans Home-Koscius
310 Autumn Ridge Drive
Kosciusko, MS 39090

CI MS #15664

Dear Mr. Allen:

This letter confirms the results of a complaint investigation conducted in your facility on **February 8, 2019**. An unannounced visit was made regarding allegation(s) of staff to resident abuse, neglect, and/or misappropriation of resident property.

Following our investigation, the allegation(s) was/were substantiated; however, no deficiencies were cited against the facility. Enclosed is a Form CMS-2567 and no Plan of Correction is required. Subsequent, a signature and a date is required and must be submitted by ten (10) calendar days after the facility receives its Form CMS-2567 by certified mail. Return the signed and dated form CMS-2567 to **Linda Pate, Division Director II, Northwest District, Post Office Box 1700, Jackson, Mississippi 39215-1700, phone number (601) 364-1100, and fax number (601) 364-5052.**

We appreciate the courtesy and cooperation you and your staff extended to the surveyor(s) during this visit. If our agency can be of further assistance, please feel free to contact **Linda Pate, Division Director II, Northwest District.**

Sincerely,

Linda Pate, Division Director II
Northwest District
Bureau of Health Facilities
Licensure and Certification

LP/dhc
Enclosure:

cc: Marilynn Winborne, Bureau Director, Long Term Care Division
Melissa Parker, Director/Office of Licensure

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
	04KO	A. BUILDING: _____ B. WING _____	C 02/08/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MS STATE VETERANS HOME-KOSCIUS	310 AUTUMN RIDGE DRIVE KOSCIUSKO, MS 39090

(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 CI MS #15664 A complaint investigation was conducted in your facility on 2/8/19. The results of the investigation was substantiated with no deficiencies.	M 000		

Administrator 3/19/19

Mississippi State Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE