

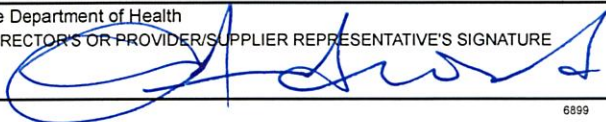
MSDH - Health Facilities Licensure and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 04KO	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 03/17/2025
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NAME OF PROVIDER OR SUPPLIER MS STATE VETERANS HOME-KOSCIUS	STREET ADDRESS, CITY, STATE, ZIP CODE 310 AUTUMN RIDGE DRIVE KOSCIUSKO, MS 39090
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(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 On 03/17/25 the State Agency (SA) conducted an onsite complaint investigation for CI MS #28251 that alleged resident to resident abuse. The SA determined that the facility was in compliance with the State Regulations and Rules for the Aged and Infirmed. The facility was licensed for 125 beds and the census was 116 at the time of survey.	M 000		

Mississippi State Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE



TITLE

Administrator

(X6) DATE

3/31/25