

MSDH - Health Facilities Licensure and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 07CH	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 05/13/2025
NAME OF PROVIDER OR SUPPLIER BRUCE COMMUNITY LIVING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 176 HIGHWAY 9 SOUTH BOX 1280 BRUCE, MS 38915		
(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) MS# 28745, CI MS# 28746, CI MS# 28748, and CI MS# 28796 at the facility on 5/13/25. During the survey, the SA determined that the facility was in compliance with the requirements of the Mississippi Regulations for Minimum Standards for Institutions for Aged or Infirm with no deficiencies cited. The census at the time of the survey was 31 with a bed capacity of 35 beds.	M 000		

Mississippi State Department of Health

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

TITLE

(X6) DATE

Electronically Signed

05/19/25