

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 06/19/2025
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NAME OF PROVIDER OR SUPPLIER BRUCE COMMUNITY LIVING CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 176 HIGHWAY 9 SOUTH BOX 1280 BRUCE, MS 38915
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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 The State Agency (SA) conducted a complaint investigation (CI) MS #29214 at the facility on 06/19/25. During the survey, the SA determined that the facility was in compliance with the Minimum Standards for Institutions for the Aged or Infirm and there were no deficiencies cited. The census at the time of the survey was 32 and they held a license for 35 beds.	M 000		

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

TITLE

(X6) DATE

Electronically Signed

06/24/25