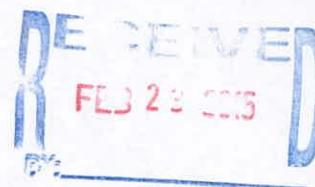


MSDH - Health Facilities Licensure and Certification

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 01/21/2015
NAME OF PROVIDER OR SUPPLIER MS STATE VETERANS HOME-KOSCIUS		STREET ADDRESS, CITY, STATE, ZIP CODE 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 The annual survey of 1/21/15 revealed that the facility was in substantial compliance for State Licensure requirements. No deficiencies were cited.	M 000		



Mississippi State Department of Health

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

TITLE

(X6) DATE

STATE FORM

6899

THQM11

If continuation sheet 1 of 1

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/18/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 04KO	(X2) MULTIPLE CONSTRUCTION A. BUILDING B1 - MAIN BUILDING B. WING _____		(X3) DATE SURVEY COMPLETED 01/30/2015
NAME OF PROVIDER OR SUPPLIER MS STATE VETERANS HOME-KOSCIUS			STREET ADDRESS, CITY, STATE, ZIP CODE 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) COMPLETION DATE	
K 000	INITIAL COMMENTS 42 CFR 483.70(a) The facility meets the applicable provisions of the 2000 (existing) Edition of the Life Safety Code (LSC) of the National Fire Protection Association (NFPA). There were no LSC deficiencies cited during this survey.	K 000			

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

TITLE

(X6) DATE

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.