

MSDH - Health Facilities Licensure and Certification

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|---------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                       |                                                                                                                                                                                                      | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>04KO</b>                       | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   | (X3) DATE SURVEY<br>COMPLETED<br><br><b>C</b><br><b>12/02/2016</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>MS STATE VETERANS HOME-KOSCIUS</b> |                                                                                                                                                                                                      | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>310 AUTUMN RIDGE DRIVE<br/>KOSCIUSKO, MS 39090</b> |                                                                                                                          |                                                                    |
| (X4) ID<br>PREFIX<br>TAG                                                  | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                         | ID<br>PREFIX<br>TAG                                                                            | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE                                           |
| M 000                                                                     | Initial Comments<br><br>CI MS #14306<br><br>A complaint investigation was conducted in your<br>facility on 12/2/16. The result of the investigation<br>was substantiated with no deficiencies cited. | M 000                                                                                          |                                                                                                                          |                                                                    |

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

TITLE

(X6) DATE