

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 01/04/2017
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 CI MS #14336 A complaint investigation was conducted in your facility on 1/4/17. The result of the investigation was substantiated with no deficiencies cited.	M 000		1/25/17

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

TITLE

(X6) DATE

Clark L. Knight, Jr.

Administrator

1/25/17

STATE FORM

6899

9WB111

If continuation sheet 1 of 1

