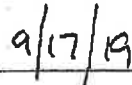


MSDH - Health Facilities Licensure and Certification

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 08/28/2019
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 #15975, CI MS #16057, CI MS #16100 & CI MS #16114 A complaint investigation was conducted in your facility on 8/28/19. The results of the investigation was unsubstantiated with no deficiencies.	M 000		
				

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

TITLE

(X6) DATE