

MSDH - Health Facilities Licensure and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 16CO	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 06/09/2017
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NAME OF PROVIDER OR SUPPLIER MS STATE VETERANS HOME-COLLINS	STREET ADDRESS, CITY, STATE, ZIP CODE 3261 HIGHWAY 49 SOUTH COLLINS, MS 39428
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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 CI MS #14525 The State Agency conducted a complaint investigation from 6/9/17 in your facility. The result of the investigation was substantiated with no deficiencies cited.	M 000		

Mississippi State Department of Health

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

Immie Car

TITLE

Administrator

(X6) DATE

7/5/2017

DATE FORM

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SPTZ11

If continuation sheet 1 of 1