

MSDH - Health Facilities Licensure and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 25JA	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 12/26/2018
NAME OF PROVIDER OR SUPPLIER MS STATE VETERANS HOME-JACKSON		STREET ADDRESS, CITY, STATE, ZIP CODE 4607 LINDBERGH DRIVE JACKSON, MS 39209			
(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 #15557 A complaint investigation was conducted in your facility on 12/26/18. 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
Heard M. Johnson
STATE FORM 6896 OVK11 TITLE Administrator (X6) DATE 1/7/19
If continuation sheet 1 of 1