

MSDH - Health Facilities Licensure and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 29CY	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R-C 09/18/2024
NAME OF PROVIDER OR SUPPLIER COURTYARDS COMM LIVING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 907 EAST WALKER STREET FULTON, MS 38843		
(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 On 9/17/24 through 9/18/24, the State Agency (SA) conducted an onsite revisit related to the complaint survey that was completed on 8/1/24. The information reviewed confirmed the facility had put measures in place to correct the deficient practice and sustain compliance with the Minimum Standards of Operation for Institutions for Aged or Infirm. The SA is recommending that your facility be placed back in compliance effective 9/9/24. Census at the time of the survey was 64 and the facility held a license for 66 beds.	{M 000}		

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

TITLE

(X6) DATE

Electronically Signed

09/30/24