

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 C 11/02/2022
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 11/02/22 the State Agency (SA) conducted onsite complaint investigations, MS00019669 for alleged neglect of a resident's care and MS00019734 for neglect resulting in a fall and ultimate death of a resident. The SA did not substantiate the allegation of neglect and abuse for either of the complaints and no deficiencies were cited. The SA determined that the facility was in substantial compliance with the regulations for the Aged and Infirmed. The resident census was 63 and the facility held a license for 66 beds on 11/02/2022.	M 000			

Mississippi State Department of Health

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

TITLE

(X6) DATE

Electronically Signed

11/16/22