

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255145	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R-C 05/28/2024
NAME OF PROVIDER OR SUPPLIER COURTYARD REHABILITATION AND HEALTHCARE			STREET ADDRESS, CITY, STATE, ZIP CODE 501 SOUTH LOCUST STREET MCCOMB, MS 39648		
(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) COMPLETION DATE
{F 000}	INITIAL COMMENTS On 05/28/24 the State Agency (SA) conducted a desk review of the information that was provided to our agency related to the complaint survey that was completed on 04/17/24. The information provided by the facility confirmed the facility had put measures in place to correct the deficient practice and sustain compliance with Medicare and Medicaid requirements of participation. The SA is recommending that your facility be placed back in compliance effective 05/22/24.	{F 000}			

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

Electronically Signed

TITLE

(X6) DATE
06/12/2024