

MSDH - Health Facilities Licensure and Certification

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| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>29CY</b>                          | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   | (X3) DATE SURVEY<br>COMPLETED<br><br><b>C</b><br><b>12/17/2024</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>COURTYARDS COMM LIVING CENTER</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>907 EAST WALKER STREET</b><br><b>FULTON, MS 38843</b> |                                                                                                                          |                                                                    |
| (X4) ID<br>PREFIX<br>TAG                                                 | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                   | ID<br>PREFIX<br>TAG                                                                               | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE                                           |
| M 000                                                                    | <p>Initial Comments</p> <p>On 12/17/24 the State Agency (SA) conducted an onsite complaint investigation, CI MS #27346. Although, the current investigation resulted in no deficiencies being cited, the facility remains Out of Compliance with the Mississippi Regulations for Minimum Standards for Institutions for Aged or Infirm due to deficiencies cited on the 12/11/24-12/12/24 survey.</p> <p>On 12/17/24 the facility was licensed for 66 beds and the resident census was 61.</p> | M 000                                                                                             |                                                                                                                          |                                                                    |

Mississippi State Department of Health

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

TITLE

(X6) DATE

Electronically Signed

12/30/24