

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 01/23/2025
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 The State Agency (SA) conducted a complaint survey, MS #27498, MS #27592, MS #27682 at the facility from 1/21/25 through 1/23/25. The SA determined that the facility was in compliance with the Mississippi Regulations for Minimum Standards for Institutions for Aged or Infirm and did not substantiate the complaints and cited no deficiencies. However, the facility remains out of compliance due to deficiencies cited on the 12/11/24 complaint survey. The census at the time of the survey was 59 with a bed capacity of 66 beds.	M 000		

Mississippi State Department of Health

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

TITLE

(X6) DATE

Electronically Signed

02/10/25