

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>04/30/2025</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>The State Agency (SA) conducted a complaint investigation (CI MS #28663 and CI MS #28734) at the facility on 04/30/25. During the survey, the SA determined that the facility was in compliance with the Minimum Standards of Operation for Institutions of Aged or Infirm, state licensure requirements and there were no deficiencies cited.</p> <p>The facility had a census of 61 at the time of the survey and they held a license for 66 beds.</p> | M 000                                                                                             |                                                                                                                          |                                                                    |

Mississippi State Department of Health

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

TITLE

(X6) DATE

Electronically Signed

05/09/25