

MSDH - Health Facilities Licensure and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 57ME	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 10/04/2021
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) COMPLETE DATE
M 000	Initial Comments The State Agency (SA) conducted a complaint survey, MS #18005 at the facility on 10/4/21. During the survey, the SA determined was unable to substantiate the complaint of allegations of substandard quality of care and cited no deficiencies. However, the facility remains out of compliance due to deficiencies cited on 9/30/21 complaint investigations for CI MS #17609 and CI MS #17315. The census at the time of the survey was 114, and the facility held a license for 140 beds.	M 000		

Mississippi State Department of Health

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

TITLE

(X6) DATE

Electronically Signed

10/21/21