

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 R-C 07/25/2023
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 follow-up revisit at the facility from 7/24/23 through 7/25/23 related to a complaint survey that was conducted 6/26/23 through 6/27/23. The SA found the corrective measures put in place by the facility corrected the deficiencies cited on the 6/27/2023 survey as of 7/17/23.	{M 000}		

Mississippi State Department of Health

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

TITLE

(X6) DATE

Electronically Signed

08/07/23