

MSDH - Health Facilities Licensure and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 61MS	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 05/13/2024
NAME OF PROVIDER OR SUPPLIER METHODIST SPECIALTY CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1 LAYFAIR DRIVE SUITE 500 FLOWOOD, MS 39232		
(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 On 05/13/24 the State Agency (SA) conducted a desk review of the information that was provided to our agency related to the annual survey that was completed on 04/11/24. The information provided by the facility confirmed the facility was in compliance with the Minimum Standards of Operation for Institutions for the Aged or Infirm. The SA is recommending that your facility be placed back in compliance effective 05/11/24.	{M 000}		

Mississippi State Department of Health

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

TITLE

(X6) DATE

Electronically Signed

05/15/24