

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 C 10/01/2024
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 The State Agency (SA) conducted three (3) Complaint investigations (CI MS# 26546, CI MS# 26590, and CI MS# 26605) at the facility on 09/30/24 - 10/01/24. CI MS#26546 was investigated for Quality of Life, Quality of Care related to resident not groomed adequately and care not received per physician instructions and Resident Neglect related to pressure sores. CI MS#26590 was investigated for Quality of Care related to call bells not operative, Resident Neglect related to medications, Physical Environment related to equipment not maintained and Death. CI MS#26605 was investigated for Quality of Life, Quality of Care/Treatment related to resident safety and for Injury of Unknown Origin. SA determined there was no deficient practice. During the survey, the SA determined the facility was in compliance with the Minimum Standards for Institutions for the Aged or Infirm, state licensure requirement. There were no deficiencies cited.	M 000		

Mississippi State Department of Health

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

TITLE

(X6) DATE

Electronically Signed

10/07/24