STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25A414	A. BUILDING _____ B. WING _____	C 10/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
METHODIST SPECIALTY CARE CENTER	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) COMPLETION DATE
F 000	INITIAL COMMENTS The State Agency (SA) conducted three (3) Complaint Iinvestigations (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 requirements for participation in Medicare and Medicaid and there were no deficiencies cited. At the time of the survey the facility was licensed for 60 beds and had a census of 58 residents.	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		10/07/2024

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.