STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 25A414	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 10/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
METHODIST SPECIALTY CARE CENTER	**1 LAYFAIR DRIVE SUITE 500 1 LAYFAIR DRIVE SUITE 500, FLOWOOD, Mississippi, 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
F0000	INITIAL COMMENTS The State Agency (SA) conducted a Complaint Investigation (CI) MS# 2648872 at the facility on 10/30/25. CI MS #2648872 was investigated related to nursing services and quality of care. During the survey, the SA determined the facility was not in compliance with the requirements for participation in Medicare and Medicaid and cited F658. The facility held a license for 60 beds, with a census of 59.	F0000		
F0658 SS = D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and record review, the facility failed to ensure that services provided met professional standards of quality related to wound care orders for one (1) of four (4) sampled residents (Resident #1). Findings include: On 10/30/25 at 10:33 AM, during a telephone interview the complainant for CI MS# 2648872 revealed she had visited Resident #1 at the facility on 10/12/25 and observed that the resident had a silver dollar sized blister on the resident's left foot. She stated that she was concerned that the wound care was not being done according to physician's orders. She reported that when she questioned the charge nurse, the nurse did was not able to provide information regarding the wound. Record review of the "Admission Record: revealed the facility admitted Resident #1 on 5/13/21 with diagnoses that included, and the resident had diagnoses of	F0658		

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 reverse for further 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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F0658 SS = D	Continued from page 1 quadriplegia, C5-C7 complete. Record review of the Quarterly Minimum Data Set (MDS) with Assessment Reference Date (ARD) 9/24/25 for Resident #1 revealed the resident had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident was cognitively intact. Section GG indicated revealed that Resident #1 was dependent for all activities of daily living, unable to stand or walk and dependent on a respirator. Record review of the “Care Profile” revealed physician orders for Resident #1 that included “Right foot: Protect with dry dressing. Change M/W/F (Monday, Wednesday, Friday) Assess every shift RN (Registered Nurse) every day shift” with a start date of 10/18/24, “ruptured blister to left heel: Clean with normal saline, Pat dry with gauze. Apply calcium alginate to wound bed cover with outer dressing. Mange M/W/F and PRN (as needed) soilage/dislodgment every day shift” with a start date of 10/28/25 and “LEFT GREAT TOE OPEN LESION: CLEAN WITH NS (normal saline), PAT DRY WITH GAUZE, APPLY CALCIUM ALGINATE TO WOUND BED. COVER WITH OUTER DRESSING, CLEAN M/W/F AND PRN FOR SOILAGE/DISLODGEMENT. EVERY DAY SHIFT” with a start date of 10/02/25. Record review of the Treatment Administration Record for Resident #1 for October 2025 revealed documentation signed by RN #2 of the application of dry dressing to right foot, application of calcium alginate with outer dressing on ruptured blister on left heel, treatment and application of dressing to toes of the resident’s left foot on 10/29/25. Record review of the Progress Notes for Resident #1 dated 10/11/15 through 10/13/25 revealed that nursing staff identified a new skin issue on Resident #1’s left foot. On 10/30/25 at 2:00 PM, interview with the Director of Nurses (DON) revealed she had received a call from the RR for Resident #1 on or around 10/13/25 inquiring about a new skin issue on the resident’s left foot/heel and wound cate concerns. She confirmed that there was documentation that nursing staff had identified the new skin issue on 10/11/25. She stated that she expected the nursing staff to provide care according to the residents’ plan of care and physician orders according to current professional standards of practice and infection control standards. She confirmed that the nurses assigned to the care of each resident and the Nurse Supervisor were, along with herself, responsible for supervision of resident care. She stated that the	F0658		

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F0658 SS = D	Continued from page 2 facility had contracted wound care that were present in the facility five (5) days weekly, Monday through Friday and that if wound care was ordered or needed on Saturday or Sunday, the resident's assigned nurse for the shift would be responsible for provision of wound care. She confirmed that the facility instructed all Certified Nurses' Aides (CNAs) to notify the resident's assigned nurse if there were new skin concerns identified, or any problem noted with soilage or dislocation of existing dressing. On 10/30/25 at 3:00 PM, observation of Resident #1, with the DON and Administrator in attendance, revealed the resident had a flex heel boot on each foot with no dressing on her left or right foot. There was a sliver dollar sized (approximately 1.5 inches in diameter) ruptured blister on the inner aspect of her left heel with an approximately 1/8 inch by ¼ inch open area. Note: 1/8 inch is the approximate width of two stacked pennies, ¼ inch is the approximate width of four stacked pennies. On 10/30/25 at 3:24 PM, during an interview CNA #2 confirmed she had been on duty for the dayshift (7:00 AM through 3:00 PM) on 10/12/25 and that she made rounds for her assigned resident group twice between 7:00 AM and 10:30 AM, which included Resident #1. She stated that there had been a reconfiguration of resident assignments at approximately 10:30 AM and CNA #3 was assigned to Resident #1 at that time. She stated that she had checked Resident #1 during that time. On 10/30/25 at 3:35 PM, interview with Registered Nurse (RN) #2 revealed that she and RN #1 were contracted wound care certified nurses and worked Monday through Friday at the facility. RN #2 confirmed that she and RN #1 had provided wound care and dressing changes for Resident #1 on 10/29/25 and said she would expect to find dressings with their initials and dated "10/29/25" on both (left and right) feet of Resident #1 and could not explain why there were not any in place at 3:00 PM. She stated that the next scheduled dressing changes were due on 10/31/25. RN #2 explained that the importance of the dry dressing ordered for Resident #1's right foot was to prevent skin injury, and she confirmed that the resident had open area on her left foot with an order for calcium alginate to provide a moist wound environment that promoted epithelial cell growth and wound closure with antimicrobial agents. RN #2 explained that the wound care orders for Resident #1 included orders for the dressings to be changed as needed for soilage and dislodgement, if the dressing became soiled or displaced during hours or days when they were not on duty that any nurse on duty could	F0658		

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F0658 SS = D	Continued from page 3 change the dressings as needed. They confirmed that CNAs were instructed to report soilage or dislodgement of dressings to the residents assigned nurse. On 10/30/25 at 4:00 PM, an interview with RN #3 revealed she was the RN Supervisor for the Dayshift on 10/30/25 and said she did not know why Resident #1's dressings were not in place or why no one reported that the dressings needed to be changed or reapplied. She stated she did know when the dressings were removed or why. She confirmed that she and the other nurses were responsible for supervision of resident care. On 10/30/25 at 4:45 PM, during an interview the Administrator and DON confirmed that they had observed that Resident #1 had no dressings in place on her feet at 3:00 PM and that it was the responsibility of the nurses to supervise the care of residents and the responsibility of the CNAs to report any issues with soilage or dislodgment of wound care dressings to the nurses. The DON and Administrator confirmed that Resident #1 should have had dressings in place on her right and left feet according to physician's orders. The Administrator and DON confirmed that failure to ensure that Resident #1's dressings were clean, intact and applied correctly was not acceptable according to professional standards of practice.	F0658		