

Mississippi State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 10/30/2025	
NAME OF PROVIDER OR SUPPLIER METHODIST SPECIALTY CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 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
M0000	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 in compliance with the Minimum Standards for Institutions for the Aged or Infirm, state licensure requirements.			M0000			

Office of Primary Care and Health Systems Management

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