

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 04/07/2021
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 the Complaint Investigations, CI # 17704 and CI #16734, from 04/06/2021 to 04/07/2021. The SA determined the facility was in compliance with the Minimum Standards of Operation for Institutions for the Aged or Infirm, State Licensure requirements.	M 000		

Mississippi State Department of Health

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

TITLE

(X6) DATE