MSDH - Health Facilities Licensure and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	61MS	A. BUILDING: _____ B. WING _____	C 12/05/2019

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) COMPLETE DATE
M 000	Initial Comments The State Agency (SA) conducted the annual re-certification survey along with the complaint (s) survey, MS # 15909, MS # 15794, and MS #16405 from 12/03/19 to 12/04/19. During the survey, the SA determined the facility was in compliance with the requirements for participation in Medicare and Medicaid. The SA was unable to substantiate MS # 15909 for the allegation of Quality of Care and no deficiencies cited; the SA was Unable to substantiate MS #15794 for Privacy and Personal Property and the SA was unable to substantiate MS # 16405 for Quality of Care. Census 58/Licensed beds 60.	M 000		

Mississippi State Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE