

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/12/2020
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 25A414	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/05/2019
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) COMPLETION DATE
F 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 12/05/19. 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.	F 000			

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

TITLE

(X6) DATE

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.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 25A414	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - METHODIST SPECIALTY CARE CENTER B. WING _____		(X3) DATE SURVEY COMPLETED 12/04/2019
NAME OF PROVIDER OR SUPPLIER METHODIST SPECIALTY CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1 LAYFAIR DRIVE SUITE 500 FLOWOOD, MS 39232		
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K 000	INITIAL COMMENTS 42 CFR 483.70(a) The facility meets the applicable provisions of the 2012 (existing) Edition of the Life Safety Code (LSC) of the National Fire Protection Association (NFPA). There were no LSC deficiencies cited during this survey.	K 000			

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NAME OF PROVIDER OR SUPPLIER METHODIST SPECIALTY CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1 LAYFAIR DRIVE SUITE 500 FLOWOOD, MS 39232		
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E 000	Initial Comments ***** Survey conducted on 12/04/19 reveals the above facility meets all applicable Federal, State and local emergency preparedness requirements. No deficiencies were cited.	E 000			

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