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 **07/14/2026**
NAME OF PROVIDER OR SUPPLIER **METHODIST SEPCIALTY CARE CENTER**		STREET ADDRESS, CITY, STATE, ZIP CODE **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 On 07/14/26 the State Agency (SA) conducted a desk review of the information that was provided to our agency related to the annual recertification/complaint survey that was completed from 06/1/26-06/4/26. The information provided by the facility confirmed the facility was in compliance with the Minimum Standards of Operation for Institutions for the Aged or Infirm. The SA is recommending your facility be placed back in compliance effective 07/10/26.	M0000		

Office of Primary Care and Health Systems Management

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