

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  10/30/2025
NAME OF PROVIDER OR SUPPLIER  Methodist Specialty Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  1 Layfair Drive Suite 500 Flowood, MS 39232	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0658  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality.  (continued on next page)

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.

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

TITLE

(X6) DATE

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  10/30/2025
NAME OF PROVIDER OR SUPPLIER  Methodist Specialty Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  1 Layfair Drive Suite 500 Flowood, MS 39232	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Based on observation, interview, and record review, the facility failed to ensure that services provided met professional standards of quality related to wound care orders for one (1) of four (4) sampled residents (Resident #1). Findings include: On 10/30/25 at 10:33 AM, during a telephone interview the complainant for CI MS# 2648872 revealed she had visited Resident #1 at the facility on 10/12/25 and observed that the resident had a silver dollar sized blister on the resident's left foot. She stated that she was concerned that the wound care was not being done according to physician's orders. She reported that when she questioned the charge nurse, the nurse did was not able to provide information regarding the wound. Record review of the admission Record: revealed the facility admitted Resident #1 on 5/13/21 with diagnoses that included, and the resident had diagnoses of quadriplegia, C5-C7 complete. Record review of the Quarterly Minimum Data Set (MDS) with Assessment Reference Date (ARD) 9/24/25 for Resident #1 revealed the resident had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident was cognitively intact. Section GG indicated revealed that Resident #1 was dependent for all activities of daily living, unable to stand or walk and dependent on a respirator. Record review of the Care Profile revealed physician orders for Resident #1 that included Right foot: Protect with dry dressing. Change M/W/F (Monday, Wednesday, Friday) Assess every shift RN (Registered Nurse) every day shift with a start date of 10/18/24, ruptured blister to left heel: Clean with normal saline, Pat dry with gauze. Apply calcium alginate to wound bed cover with outer dressing. Mangle M/W/F and PRN (as needed) soilage/dislodgment every day shift with a start date of 10/28/25 and LEFT GREAT TOE OPEN LESION: CLEAN WITH NS (normal saline), PAT DRY WITH GAUZE, APPLY CALCIUM ALGINATE TO WOUND BED. COVER WITH OUTER DRESSING, CLEAN M/W/F AND PRN FOR SOILAGE/DISLODGE MENT. EVERY DAY SHIFT with a start date of 10/02/25. Record review of the Treatment Administration Record for Resident #1 for October 2025 revealed documentation signed by RN #2 of the application of dry dressing to right foot, application of calcium alginate with outer dressing on ruptured blister on left heel, treatment and application of dressing to toes of the resident's left foot on 10/29/25. Record review of the Progress Notes for Resident #1 dated 10/11/15 through 10/13/25 revealed that nursing staff identified a new skin issue on Resident #1's left foot. On 10/30/25 at 2:00 PM, interview with the Director of Nurses (DON) revealed she had received a call from the RR for Resident #1 on or around 10/13/25 inquiring about a new skin issue on the resident's left foot/heel and wound care concerns. She confirmed that there was documentation that nursing staff had identified the new skin issue on 10/11/25. She stated that she expected the nursing staff to provide care according to the residents' plan of care and physician orders according to current professional standards of practice and infection control standards. She confirmed that the nurses assigned to the care of each resident and the Nurse Supervisor were, along with herself, responsible for supervision of resident care. She stated that the facility had contracted wound care that were present in the facility five (5) days weekly, Monday through Friday and that if wound care was ordered or needed on Saturday or Sunday, the resident's assigned nurse for the shift would be responsible for provision of wound care. She confirmed that the facility instructed all Certified Nurses' Aides (CNAs) to notify the resident's assigned nurse if there were new skin concerns identified, or any problem noted with soilage or dislocation of existing dressing. On 10/30/25 at 3:00 PM, observation of Resident #1, with the DON and Administrator in attendance, revealed the resident had a flex heel boot on each foot with no dressing on her left or right foot. There was a silver dollar sized (approximately 1.5 inches in diameter) ruptured blister on the inner aspect of her left heel with an approximately 1/8 inch by 1/4 inch open area. Note: 1/8 inch is the approximate width of two stacked pennies, 1/4 inch is the approximate width of four stacked pennies. On 10/30/25 at 3:24 PM, during an interview CNA #2 confirmed she had been on duty for the dayshift (7:00 AM through 3:00 PM) on 10/12/25 and that she made rounds for her assigned resident group twice between 7:00 AM and 10:30 AM, which included Resident #1. She stated that there had been a reconfiguration of resident assignments at approximately 10:30 AM and CNA #3 was assigned to Resident #1 at that time. She stated that she had checked Resident #1 during that time. On 10/30/25 at 3:35 PM, interview with Registered Nurse (RN) #2 revealed that she and RN #1 were contracted wound care certified nurses and worked Monday through Friday at the facility. RN #2 confirmed that she and RN #1 had provided wound care and dressing changes for Resident #1 on 10/29/25 and said she would expect to find dressings with their initials and dated 10/29/25 on both (left and right) feet of Resident #1 and could not explain why there were not any in place at 3:00 PM. She stated that the next scheduled dressing changes were due on 10/31/25. RN #2 explained that</p>		