

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255273	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/28/2024
NAME OF PROVIDER OR SUPPLIER PARKWAY HEALTH & REHAB LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 230 RIVER OAKS DRIVE CANTON, MS 39046		
(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 On 05/28/24 the State Agency (SA) conducted two (2) Complaint Investigations (CI MS #25190 and CI MS #25241), which alleged that a resident was admitted to a local emergency room with injuries that possibly could have been caused by a sexual encounter. The SA determined that the facility was in compliance with the requirements of participation in Medicare and Medicaid Services. The facility was licensed for 87 beds and the resident census was 84 on 05/28/24.	F 000			

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

Electronically Signed

TITLE

(X6) DATE

06/12/2024