STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25CR	A. BUILDING: _____ B. WING _____	03/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKWAY HEALTH & REHAB LLC	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) COMPLETE DATE
M 000	Initial Comments The State Agency (SA) conducted an annual re-certification survey at the facility from 3/11/25-3/13/25. During the survey, the SA determined the facility was not in compliance with the Mississippi Regulations for Minimum Standards for Institutions for the Aged or Infirm and cited M 500, M 610, M 625, M 645, M 705, M 815, and M 1570. The census at the time of the survey was 79 and the facility is licensed for 87 beds.	M 000		
M 500	45.17.2 Residents' Rights Residents' Rights. The residents' rights policies and procedures ensure that each resident admitted to the facility: 1. is fully informed, as evidenced by the resident's written acknowledgment, prior to or at the time of admission and during stay, of these rights and is given a statement of the facility's rules and regulations and an explanation of the resident's responsibility to obey all reasonable regulations of the facility and to respect the personal rights and private property of other residents; 2. is fully informed, and is given a written statement prior to or at time of admission and during stay, of services available in the facility, and of related charges including any charges for services covered by the facility's basic per diem rate; 3. is assured of adequate and appropriate medical care, is fully informed by a physician or nurse practitioner/physician assistant of his medical conditions unless medically contraindicated (as documented by a physician or	M 500		4/18/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25CR	A. BUILDING: _____ B. WING _____	03/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKWAY HEALTH & REHAB LLC	230 RIVER OAKS DRIVE CANTON, MS 39046

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M 500	Continued From page 1 nurse practitioner/physician assistant in his medical record), is afforded the opportunity to participate in the planning of his medical treatment, to not be limited in his/her choice of a pharmacy or pharmacist provider in accordance with state law, as referenced in House Bill 1439, which states that the facility shall not limit a resident ' s choice of pharmacy or pharmacy provider if that provider meets the same standards of dispensing guidelines required of long term care facilities, to refuse to participate in experimental research, and to refuse medication and treatment after fully informed of and understanding the consequences of such action; 4. is transferred or discharged only for medical reasons, or for his welfare or that of other residents, or for nonpayment for his stay (except as prohibited by sources of third-party payment), and is given a two weeks advance notice in writing to ensure orderly transfer or discharge. A copy of this notice is maintained in his medical record; 5. is encouraged and assisted, throughout his period of stay, to exercise his rights as a resident and as a citizen, and to this end may voice grievances, has a right of action for damages or other relief for deprivations or infringements of his right to adequate and proper treatment and care established by an applicable statute, rule, regulation or contract, and to recommend changes in policies and services to facility staff and/or to outside representatives of his choice, free from restraint, interference, coercion, discrimination, or reprisal; 6. may manage his personal financial affairs, or is given at least a quarterly accounting of financial	M 500		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25CR	A. BUILDING: _____ B. WING _____	03/13/2025

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M 500	Continued From page 2	M 500		

transactions made on his behalf should the facility accept his written delegation of this responsibility to the facility for any period of time in conformance with State law;

7. is free from mental and physical abuse;
8. is free from restraint except by order of a physician or nurse practitioner/physician assistant, or unless it is determined that the resident is a threat to himself or to others. Physical and chemical restraints shall be used for medical conditions that warrant the use of a restraint. Restraint is not to be used for discipline or staff convenience. The facility must have policies and procedures addressing the use and monitoring of restraint. A physician order for restraint must be countersigned within 24 hours of the emergency application of the restraint;
9. is assured security in storing personal possessions and confidential treatment of his personal and medical records, and may approve or refuse their release to any individual outside the facility, except, in the case of his transfer to another health care institution, or as required by law of third-party payment contract;

10. is treated with consideration, respect, and full recognition of his dignity and individuality, including privacy in treatment and in care for his personal needs;

11. is not required to perform services for the facility that are not included for therapeutic purposes in his plan of care;

12. may associate and communicate privately with persons of his choice, may join with other residents or individuals within or outside of the facility to work for improvements in resident care,

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	25CR	A. BUILDING: _____ B. WING _____	03/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKWAY HEALTH & REHAB LLC	230 RIVER OAKS DRIVE CANTON, MS 39046

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M 500	Continued From page 3 and send and receive his personal mail unopened, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 13. may meet with, and participate in activities of, social, religious and community groups at his discretion, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 14. may retain and use his personal clothing and possessions as space permits, unless to do so would infringe upon rights of other residents, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 15. if married, is assured privacy for visits by his/her spouse; if both are inpatients in the facility, they are permitted to share a room, unless medically contraindicated (as documented by the attending physician or nurse practitioner/physician assistant in the medical record); and 16. is assured of exercising his civil and religious liberties including the right to independent personal decisions and knowledge of available choice. The facility shall encourage and assist in the fullest exercise of these rights. This Statute is not met as evidenced by: Level II Based on observation, staff and resident interviews, record review, and facility policy, the facility failed to ensure a resident's right to be free	M 500	* On 3-13-25, the Director of Nursing (DON), removed the bed and chair alarm from Resident #67 room. On 3-13-25, the DON, removed all bed and chair alarms from the general supply room to ensure	

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	25CR	A. BUILDING: _____ B. WING _____	03/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKWAY HEALTH & REHAB LLC	230 RIVER OAKS DRIVE CANTON, MS 39046

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M 500	Continued From page 4 from physical restraints when a bed alarm pad and a wheelchair alarm pad were used that restricted the resident's movements. The alarms caused the resident to stop moving to avoid triggering the alarm sounds, demonstrating a restrictive effect for one (1) of two (2) residents reviewed for restraints. (Resident #67) Findings include: Review of the facility policy titled "Use of Restraints," revised April 2017, revealed "Policy Interpretation and Implementation: 'Physical Restraints' are defined as any manual method, or physical or mechanical device, material or equipment attached or adjacent to the resident's body that the individual cannot remove easily, which restricts freedom of movement or restricts normal access to one's body..." An observation and interview with Resident #67 on 3/11/25 at 10:15 AM revealed a bed alarm pad attached to the resident's bed. During the interview, Resident #67 stated that the bed alarm went off frequently and voiced, "I hate it." He reported that when the alarm sounds, he stops moving so it will stop alarming. During an interview with Certified Nurse Assistant (CNA) #6 on 3/13/25 at 8:16 AM, she confirmed that Resident #67 had a bed alarm pad in place due to a history of frequent falls. When asked if the resident had ever complained about the alarm pad, CNA #6 stated that she had observed the resident stop moving or attempting to get up when the alarm sounded, as he did not want it to continue. When asked if she reported this behavior, she stated that she believed she did. A record review of the Order Summary report for	M 500	they could not be accessed without the proper order, care plan and consent being in place before application. * Seven (7) residents had the potential to be affected by having a bed or chair alarm placed. * On 3-25-25, the DON reviewed the care plans for each resident that has an order for a bed or chair alarm to ensure it was updated with interventions to prevent resident being "restrained" by the sound of the alarm. On 3-25-25, the DON began meeting with each resident with an order for bed or chair alarm to see if the alarm made them not "move" or if it is a reminder for them to call for help when needed. No further adverse effects were identified. On 3-26-25, the DON did an in-service for all staff that performs room rounds to inquire with the resident how they feel about the alarms and to report that in the morning staff meeting on a weekly basis; this will be on-going. On 4-2-26, the DON began an in-service with all nursing staff on the use of restraints and when an alarm becomes a restraint. * The RN Supervisor will be responsible to audit each resident weekly to determine if a bed or chair alarm stops them from moving; the DON began the audits on 3-25-25 and reported to the QA Committee on 3-26-25 at the already scheduled meeting. The Quality Assurance Committee will be notified, by the identifying staff member, of any adverse reactions to an alarm within 2	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25CR	A. BUILDING: _____ B. WING _____	03/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKWAY HEALTH & REHAB LLC	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) COMPLETE DATE
M 500	Continued From page 5 Resident #67 revealed no physician order for a bed alarm pad. Further review revealed an order dated 10/15/24 for a wheelchair/chair alarm pad to alert staff of attempts to get up unassisted. An interview with the Medicare Nurse on 3/12/25 at 8:35 AM confirmed that if Resident #67 stated he stops moving to make the alarm stop and staff reported observing the resident stopping movement in response to the alarm, the alarms would be considered a restraint. She confirmed that no restraint assessments had been completed for either alarm devices because she was unaware that the alarm was restricting the resident's movement. She also revealed the resident only had an alarm pad ordered for the wheelchair and was not aware that he had an alarm pad to the bed. During an interview with the Director of Nursing (DON) on 3/13/25 at 8:50 AM revealed that she was unaware that Resident #67 had voiced his dislike for the alarm or that it caused him to stop moving. She confirmed that while the resident had an order for an alarm pad on the wheelchair, there was no order for an alarm pad on the bed. The DON stated she did not know when or by whom the bed alarm pad was placed. She confirmed that if the resident expressed distress about the alarm and staff verified his behavior of stopping movement to silence it, both alarm devices would be considered restraints. During an interview with the Assistant Director of Nursing (ADON)/Infection Control Nurse on 3/13/25 at 3:34 PM revealed concerns about the use of restraints, stating that they could lead to anxiety or depression and hinder residents from performing daily activities independently.	M 500	hours of the complaint, as an on-going basis, to determine the risk and the benefits. The QA committee will monitor the results of said findings weekly for six (6) weeks; then quarterly for two (2) quarters.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25CR	A. BUILDING: _____ B. WING _____	03/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKWAY HEALTH & REHAB LLC	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) COMPLETE DATE
M 500	Continued From page 6 Record review of the "Admission Record" revealed Resident #67 was admitted on 1/19/2024, with a diagnoses which included Repeated Falls. A record review of Resident #67's Minimum Data Set (MDS), Section C with an Assessment Reference Date (ARD) of 2/12/2025, revealed a Brief Interview for Mental Status (BIMS) score of 7, indicating the resident was severely cognitively impaired.	M 500		
M 610	45.21.2 Activities of daily living Activities of daily living. Each resident shall receive assistance as needed with activities of daily living to maintain the highest practicable well being. These shall include, but not be limited to: 1. Bath, dressing and grooming; 2. Transfer and ambulate; 3. Good nutrition, personal and oral hygiene; and 4. Toileting. This Statute is not met as evidenced by: Level II Pattern Based on observation, resident and staff interviews, record review, and facility policy review, the facility failed to provide Activities of Daily Living (ADL) care for residents that require assistance for four (4) of seventy-nine (79) residents observed during the initial tour. Resident's #1, #34, #61 and #67 The scope/severity of this deficiency was	M 610	* On 3-13-25, the barber at the facility cut and shaved the residents #1, #34, #61 and #67. On 3-13-25, other residents also received a hair cut according to their wishes. * The majority of the residents at facility use the in-house barber; therefore, all residents could have been affected by staff not asking residents if they want a hair cut or shave.	4/18/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25CR	A. BUILDING: _____ B. WING _____	03/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKWAY HEALTH & REHAB LLC	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) COMPLETE DATE
M 610	Continued From page 7 increased to Pattern due to prior citation on the last Annual Recertification Survey. Findings include: Review of the facility policy titled, "Quality of Life," revised August 2009, revealed Policy Interpretation and Statement: 3.) "Residents shall be groomed as they wish to be groomed (hair styles, nails, facial hair, etc. (et cetera). Resident #1 An observation and interview on 3/11/25 at 9:34 AM revealed Resident #1's facial hair was approximately ¾ inch long on his chin, sides of his face, and neck area. His hair was unkempt and thick. Resident #1 stated, "The barber has not been here in quite some time. I would like to have a haircut and be shaved." He admitted that no one had asked him if he wanted to be shaved or have a haircut, and it's been a very long time. An observation on 3/12/25 at 8:20 AM revealed Resident #1 with no change in appearance from the previous day. During an interview and observation on 03/12/25 at 9:25 AM, Certified Nurse Aide (CNA) #1 revealed she was assigned to Resident #1 and confirmed he had long facial hair and needed a haircut. She admitted she was not sure if the resident wanted to be shaved because she had not asked and confirmed that she should have put him down on the barber list for a haircut. During an observation and interview on 3/12/25 at 9:35 AM, the Director of Nurses (DON) confirmed that Resident #1 needed to be shaven, and his hair needed to be cut. She stated, "He's able to	M 610	* The Quality Assurance (QA) Committee held a meeting on 3-26-25 to determine if current system of having residents hair cut was in need of any modifications. The QA Committee determined on 3-26-25 that a new system needed to be implemented to ensure each resident has the opportunity to have their hair cut monthly. The QA Committee agreed to have a "Barber Shop List" binder which would include every residents name and the date of any trips to barber shop or the refusal to have hair cut, the binder was started on 3-26-25. The social worker will be responsible to ask each resident during the first part of the month if they would like a hair cut for that month. The social worker will then make a list and follow up to ensure the hair cut was received. * Beginning on 3-13-24, the Social Worker will be responsible to ensure each resident has a hair cut or offered and declined a hair cut monthly. The Social Worker will ensure there is proper documentation made to clarify when and if the resident received a hair cut; this will be an on-going process. The QA committee will have a report provided at each weekly meeting scheduled for Wednesdays for the next 4 weeks; then monthly for two (2) months. The next scheduled QA meeting will be held 4-2-25.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25CR	A. BUILDING: _____ B. WING _____	03/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKWAY HEALTH & REHAB LLC	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) COMPLETE DATE
M 610	Continued From page 8	M 610		

tell the staff when he wants it to be done." Resident #1 replied, "But I don't know when the man comes to cut our hair." He stated to the DON that he had his haircut last year, and the barber also shaved him at that time, but that was the last time he was shaven. Resident #1 then confirmed that he would like to be shaved and have his hair cut.

A record review of the "Daily Barber Shop Charges" revealed Resident #1's last haircut was on 10/8/24.

A record review of Resident #1's Admission Record revealed the resident was admitted to the facility on 3/07/2022 with diagnoses that included Type 2 Diabetes Mellitus with Hypoglycemia without Coma, Tachycardia, and Functional Quadriplegia.

A record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of Jan 20, 2025 revealed, in Section C, a Brief Interview of Mental Status (BIMS) score of 15, which indicated Resident #1 was cognitively intact.

Resident #61

An observation and interview on 3/11/25 at 9:55 AM revealed Resident #61 had facial hair approximately 1.5 (one and one-half) inches long to his cheeks, chin, and neck and his hair was long, and greasy. Resident #61 admitted that it had been a long time since he had been shaved and had a haircut, and he wanted to have those things taken care of.

An observation on 3/12/25 at 8:20 AM revealed Resident #61 with no change in appearance from

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25CR	A. BUILDING: _____ B. WING _____	03/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKWAY HEALTH & REHAB LLC	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) COMPLETE DATE
M 610	Continued From page 9	M 610		

the previous day.

In an interview and observation on 3/12/25 at 8:55 AM, CNA #5 confirmed that Resident #61 needed to be shaved and have his hair washed and cut. She revealed that she was assigned to Resident #61 today and stated that he was "looking rough." She then stated that she wasn't sure how long it had been since the resident had a haircut or had been shaved.

A record review of Resident #61's Admission Record revealed the resident was admitted to the facility on 8/17/2022 with diagnoses that included Hypokalemia and Depression.

A record review of the MDS with an ARD of 1/6/25 revealed, in Section C, a BIMS score of 15, which indicated Resident #61 was cognitively intact.

Resident #34

An observation and interview on 3/11/25 at 10:30 AM, revealed Resident #34's hair was greasy with white flakes around the scalp edges and his face had visible facial hair. He stated he could not remember the last time his hair was washed, or he was shaved but he wanted it done.

An observation on 3/12/25 at 8:25 AM, with CNA #4, confirmed that Resident #34 appeared to have gone without a shower or hair wash for an extended period.

An observation on 3/12/2025 at 8:27 AM, with Registered Nurse (RN) #3, she confirmed Resident # 34 looked "scruffy and unkempt."

Record review of Resident #34's "Admission

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25CR	A. BUILDING: _____ B. WING _____	03/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKWAY HEALTH & REHAB LLC	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) COMPLETE DATE
M 610	Continued From page 10	M 610		

Record" revealed he was admitted to the facility on 9/11/2024, with diagnoses that included Hypertensive Heart and Chronic Kidney Disease with Heart Failure, Stage 1 through Stage 4 Chronic Kidney Disease, and Malignant Neoplasm of Bladder.

Record review of Resident #34's MDS Section C, with an ARD of 12/16/2024, revealed a BIMS score of 14, indicating the resident was cognitively intact. Section GG 0130 Self Care was coded dependent.

Resident #67

During an observation and interview with Resident #67 on 3/11/25 at 10:00 AM, the resident's face and hair appeared oily with long unkempt facial hair. The resident stated he had not been shaved in a while and could not remember when his hair was last washed.

An observation with CNA #6 on 3/12/25 at 8:16 AM confirmed that Resident #67's facial hair was unkempt, needed to be shaved, and his face and hair were oily and needed washing.

During an interview with the DON on 3/13/25 at 8:50 AM, she confirmed that all residents should receive personal hygiene daily and as needed. She acknowledged that a lack of personal hygiene could lead to potential skin issues.

Review of the ADL documentation for Resident #67 from 2/27/25-3/12/25 revealed only two days of documentation for personal hygiene.

A review of Resident #67's Admission Record revealed that he was admitted on 1/19/2024, with a diagnosis of Infrarenal Abdominal Aortic

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25CR	A. BUILDING: _____ B. WING _____	03/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKWAY HEALTH & REHAB LLC	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) COMPLETE DATE
M 610	Continued From page 11 Aneurysm. A review of the MDS, Section C, dated 2/12/25, revealed a BIMS score of 7, indicating severe cognitive impairment. A review of the MDS-Nursing (7) Seven-Day Look Back Report dated 3/12/25 documented that Resident #67 was coded as dependent for Section GG: 01301 - Personal Hygiene.	M 610		
M 625	45.21.5 Range of motion Range of motion. Residents with limited range of motion shall receive treatment and services to increase range of motion or prevent further decline in range of motion. This Statute is not met as evidenced by: Level II Pattern Based on observation, staff interview, record review, and facility policy review, the facility failed to ensure a splint was applied for a resident with contractures for one (1) of 35 residents with limited range of motion (ROM) residing in the facility. Resident #12 The scope/severity of this deficiency was increased to Pattern due to prior citation on the last Annual Recertification Survey. Findings Include: Review of the facility policy titled "Resident Mobility and Range of Motion" with a revision date of July 2017, revealed under, "Policy Statement: 1. Residents will not experience an avoidable reduction in range of motion (ROM). 2. Residents	M 625	* On 3-13-25, the Assistant Director of Nursing(ADON) applied the splint to the Resident #12. * Four(4) residents have orders to apply splints; therefore, four(4) residents had the potential to be affected by not having their splints applied. * A review completed by the Director of Nursing (DON), Assistant Director of Nursing (ADON) and the Director of Rehab (DOR) on 3-26-25 revealed that Resident #12 needed to be re-screened from previous recommendations to determine the most appropriate device for him; therefore, a new screening will be completed. During the review, it was determined that the responsibility of applying the splints would be assigned to	4/18/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25CR	A. BUILDING: _____ B. WING _____	03/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKWAY HEALTH & REHAB LLC	230 RIVER OAKS DRIVE CANTON, MS 39046

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M 625	Continued From page 12 with limited range of motion will receive treatment and services to increase and/or prevent a further decrease in ROM. 3. Residents with limited mobility will receive appropriate services, equipment and assistance to maintain or improve mobility unless reduction in mobility is unavoidable..." An observation of Resident #12 on 3/11/25 at 9:37 AM revealed he had a left upper extremity contracture with no contracture device in place. An observation of Resident #12 on 3/12/25 at 8:08 AM and again at 9:30 AM revealed the resident continued to have no device in place for the left extremity contracture. Record review of Resident #12's March 2025 Medication Administration Record (MAR) revealed an order dated 6/11/24, "Resident to wear resting hand splint to LUE (left upper extremity) daily. Put on at 8:00 AM. Leave on resident 4-6 hours as resident will allow. One time a day to prevent declining contracture report to OT (Occupational Therapy) any complications." An observation and interview with the Assistant Director of Nursing (ADON) on 3/12/25 at 9:45 AM confirmed Resident #12 was not wearing the ordered splint. She revealed the aides were responsible for applying the device and the nurses were to ensure it was applied. The ADON revealed failing to apply the splint could cause worsening contractures. An interview with Licensed Practical Nurse (LPN) #3 on 3/12/25 at 9:51 AM confirmed she did not ensure Resident #12 had on his hand splint yesterday or today. She revealed she was unsure where the splint was but thought it could be in the	M 625	the assigned nurse for each day. The ADON began in-servicing staff on 3-26-25, regarding the application of splints per physician orders, using the policy titled "Resident Mobility and Range of Motion". * On 3-17-25, the DON began audits to include 100% of the residents with splint orders at various times and various days, per week for six (6) weeks; then monthly for two (2) months. The Quality Assurance Committee reviewed plan of correction (POC) during the 3-26-24 QA meeting and approved said POC. The QA Committee will receive an update on any non-compliance concerns during the weekly QA meeting scheduled for each Wednesday for six (6) weeks, then monthly for two(2) months, then quarterly on an ongoing basis.	

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	25CR	A. BUILDING: _____ B. WING _____	03/13/2025

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M 625	Continued From page 13 laundry. She confirmed she signed off on the MAR as administered yesterday and admitted she did not go back to ensure it was applied. An interview with Certified Nurse Aide (CNA) #1 on 3/12/25 at 10:15 AM revealed she worked last night, and Resident #12 did not have his splint in his room. She stated, "I guess someone took it to laundry because he didn't have it." She confirmed she did not look for it. Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 12/26/24 revealed under section GG, Resident #12 had upper extremity (shoulder, elbow, wrist, hand) functional limitation in Range of Motion (ROM) on both sides. Record review of the "Admission Record" revealed the facility admitted Resident #12 on 12/19/24 with medical diagnoses that included Hypertensive Heart and Chronic Kidney Disease with Heart Failure and with Stage 5 Chronic Kidney Disease and End Stage Renal Disease.	M 625		
M 645	45.21.9 Nutrition Nutrition. Residents shall maintain acceptable parameters of nutritional status, such as body weight and protein levels, unless residents ' clinical condition indicates that this is unavoidable. All residents shall receive diets as orders by their physician or nurse practitioner/physician assistant. Residents identified with significant nutritional problems shall receive appropriate medical nutrition therapy based on current professional standards. This Statute is not met as evidenced by:	M 645		4/18/25

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M 645	Continued From page 14 Level II Based on dialysis staff and facility staff interview, record review, and facility policy review, the facility failed to provide nutritional and hydration care and services to meet the needs of a resident receiving both enteral feedings and dialysis for one (1) of four (4) residents reviewed for nutrition. Resident #12 Cross reference F580 Findings Include: Review of the facility policy titled "Enteral Nutrition" with a revision date of January 2014, revealed under, "Policy Statement: adequate nutritional support through enteral feeding will be provided to residents as ordered." Additionally revealed under, "8. The Dietician will monitor residents who are receiving enteral feedings and will make appropriate recommendations for interventions to enhance tolerance and nutritional adequacy of enteral feedings..." Record review of the "Registered Dietician Note" dated 2/18/25 for Resident #12 revealed, "RD (Registered Dietician) spoke with RD from dialysis regarding resident having issues with fluid overload. RD suggests changing TF (tube feeding) to Nutren 2.0 in order to meet needs for weight gain/wound healing without having excess fluids to prevent overload. Dialysis RD agrees and will monitor dialysis labs for elevated phosphorous. Dialysis RD states that fluid restriction for resident is 1000 ml (milliliters) H20 (water), however online orders (facility physician orders) show 1500 ml (milliliters) H20 (water)." Additionally revealed under, "Interventions: 1. Consult MD (physician) for fluid restriction	M 645	* On 3-13-25, the Director of Nursing (DON), contacted the dialysis clinic that Resident #12 receives services from to inquire about a faxed recommendation to decrease Resident #12 fluid intake. The recommendation was faxed to facility on 3-13-25 and the Assistant Director of Nursing (ADON) notified the primary physician and the consultant dietician to report the omission of implementing the recommendation dated 2-18-25. An order was received to implement the recommendation on 3-13-25, which was completed by the ADON on 3-13-25. On 3-14-25, the DON did a 100% audit of all the dietary recommendations received for the month of February 2025 to determine any further non-compliance, with none being identified. * All residents of the facility are followed by the consultant dietician; therefore, all residents of the facility could have been affected by an omission of implementing a recommendation. * The policy titled "Enteral Nutrition" was reviewed by the QA Committee on 3-26-25 to determine if any revisions were needed to policy; with none being identified. The QA Committee determined that auditing of the recommendations should be an on going process. * Auditing of recommendations began on 3-14-25 by the DON. The DON will be responsible to audit 100% of dietary recommendations to ensure full compliance with implementing the recommendation per the facility policy on	

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M 645	Continued From page 15 clarification. 2. Change TF (tube feeding) to Nutren 2.0 (1) can 5 times per day. Flush with 50 ml (milliliters) H20 (water) after each feeding. TF (tube feeding) will provide 2500 calories, 100 grams protein, 1125 milliliters free H20 (water) 1500 milliliters total H20 (water). 3. Change med flushes to 15 ml (milliliters) H20 (water) before and after meds. Med flushes will provide 60-90 milliliters H20 (water). Goal: WG (weight gain) to IBW (ideal body weight), TF (tube feeding) to meet needs for dialysis and desired WG (weight gain)." Record review of Resident #12's Medication Administration Record (MAR) revealed the RD recommendations dated 2/18/25 were not put in place. Record review of Resident #12's MAR revealed an order dated 2/12/25, "Enteral Feed Order ... Nepro 1 can 6 times per day via bolus. Flush with 30 ml (milliliters) H20 (water) after each feeding. Tube feeding will provide: 2560 calories, 115 grams protein, 1394 cc (cubic centimeter) free H20 (water), 1782 cc (cubic centimeter) total H20 (water)." Also revealed an order dated 3/7/25, "Enteral Feed Order every shift: Flush peg tube (Percutaneous Endoscopic Gastrostomy) with 15cc (cubic centimeters) of water before and after administration of medication and 5cc (cubic centimeters) in between each medication. Record review of Resident #12's MAR revealed an order dated 1/09/25, "Dialysis Fluid Restriction 1,500cc (cubic centimeters). " On 3/12/25 at 10:40 AM, a telephone interview with the facility RD revealed the last time she saw Resident #12 was on 2/18/25. She stated that she talked with the dialysis RD because the	M 645	a monthly basis; as on on-going process. On 3-26-25, the QA committee met and reviewed plan of correction; with approval being agreed upon. The QA committee will be updated on a weekly basis for six(6) weeks; then monthly for four (4) months for any recommendations or changes to plan of correction. The QA committee has scheduled meetings for Wednesday of each week for review.	

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M 645	Continued From page 16	M 645		

resident was having fluid overload during his dialysis treatments. She admitted they also discussed concerns about the resident's enteral feedings and not gaining weight. The RD revealed that after speaking with the dialysis RD, she was made aware that the resident should be on a 1200 ml fluid restriction. The RD explained that she made recommendations to the Director of Nurses (DON) or the Assistant Director of Nurses (ADON) that day to change the enteral feedings to Nutren 1 can bolus 5 times daily and to change up the flushes. She revealed she also recommended contacting the MD for a clarification on the fluid restriction. Furthermore, she confirmed failure to act promptly on these recommendations could place the resident at risk for continued fluid overload.

On 3/12/25 at 10:53 AM, an interview with the DON confirmed that she remembered talking to the RD and then going back and forth about Resident #12's changes. She revealed that once the RD makes a recommendation, she usually places it in the physician's folder for him or the nurse practitioner to review. She admitted that those recommendations must have been misplaced because she was unable to locate it and confirmed that they should have been put into place.

On 3/12/25 at 1:18 PM, a telephone interview with "Proper Name of Dialysis Company" RD confirmed she spoke with the Facility RD related to Resident #12 being NPO (nothing by mouth) and receiving Nepro enteral feedings and losing weight, plus concerns related to the resident's interdialytic (between dialysis sessions) weight gain. She stated that she had faxed a 1200 ml (milliliter) fluid restriction physician order to the facility on 2/20/25, but the facility continued to

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M 645	Continued From page 17	M 645		

have the resident on a 1500 ml (milliliter) fluid restriction. She expressed that the resident was normally over his pre-dialysis target weight with excessive fluid. She confirmed that if the resident did not follow the recommended fluid restriction, and the RD recommended enteral feedings/flushes then that could result in elevated blood pressure.

Record review of the "(Proper Name Dialysis) Orders Log" for Resident #12 confirmed an order dated 2/20/25, "Patient to follow a fluid restricted diet, limiting fluid intake to 1200 ml (milliliters) per day. Monitor fluid closely and report any concerns to dialysis unit."

On 3/12/25 at 1:26 PM, a telephone interview with "Proper Name of Dialysis Company" Registered Nurse (RN) Clinical Director revealed that Resident #12 was normally 3-4 kilo's (kilograms) (6.6 to 8.8 pounds) over on his pre-dialysis weight and the goal was not to be above 1 kilo (2.2) pounds or to exceed 2 kilos (4.4) pounds. She stated that the residents' last visit was on Monday 3/10/25, and he was 4 kilos (8.8) pounds over.

An interview with the DON on 3/12/25 at 2:48 PM revealed the physician was not made aware of Resident #12's new Registered Dietician (RD) recommendations via telephone because the nurse practitioner intended to come to the facility a couple of days later and could review it then. She confirmed the resident's fluid volume status was of high importance and acknowledged the physician should have been made aware as the resident had had a delay getting the care. She revealed they (the facility) did not receive the faxed physician order from dialysis to reduce Resident #12's fluid restriction to 1200 milliliters.

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M 645	Continued From page 18 Record review of the "Weights and Vitals Summary" for Resident #12 revealed the following weights: 12/03/24 115.3 pounds 12/26/24 110.4 pounds 1/03/25 - 106.9 pounds 1/17/25 - 109.1 pounds 2/03/25 - 117.7 pounds 2/17/25 - 116.6 pounds 3/07/25 - 112.6 pounds Record review of the "Admission Record" revealed the facility admitted Resident #12 on 12/19/24 with medical diagnoses that included Hypertensive Heart and Chronic Kidney Disease with Heart Failure and with Stage 5 Chronic Kidney Disease and End Stage Renal Disease.	M 645		
M 705	45.24.2 Policies and procedures Policies and procedures. Each facility shall have policies and procedures to assure the following: 1. Accurate acquiring; 2. Receiving; 3. Dispensing; 4. Storage; and 5. Administration of all drugs and biologicals.	M 705		4/18/25

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M 705	Continued From page 19 This Statute is not met as evidenced by: Level II Based on observation, resident and staff interview, record review, and facility policy review, the facility failed to ensure medications were stored appropriately and not left in the resident's room for one (1) of 23 sampled residents. Resident #10 Findings include: A review of the facility policy titled, "Storage of Medications" revised April 2007 revealed, "The facility shall store all drugs and biologicals in a safe, secure, and orderly manner." An observation on 3/11/25 at 10:15 AM revealed Resident #10 had a bottle of Tums Ultra Strength 1000 mg (milligrams)and Equate Nasal Spray 3 fluid (fl) ounces (oz) sitting on his overbed table. An observation and interview on 3/12/25 at 11:10 AM revealed Resident #10's medication of a bottle of Tums Ultra Strength 1000 mg and Equate Nasal Spray 3 fl. oz remained sitting on his overbed table. Resident #10 revealed that he has bad indigestion and needs his medicine and stated, "If they come in here and try to take them, I'll walk out right now." A record review for Resident #10 revealed there was no self-administration of medication assessment. During an interview on 3/12/25 at 11:15 AM Licensed Practical Nurse (LPN) #4 revealed she is assigned to Resident #10 and gives him his medicines; she revealed she was not aware that	M 705	* On 3-12-25, the Assistant Director of Nursing (ADON) removed over the counter (OTC) medications from Resident #10 room. On 3-12-25, the Director of Nursing (DON) called resident #10 responsible party and informed her that OTC medications were found in Resident #10 room and it has been removed. She was informed during that telephone call of the violations of having OTC medications in the room. Resident #10 was notified that he must meet a certain criteria on an assessment and have a lock box to keep medications in, if he was able to meet criteria. * The QA Committee determined, through discussion in scheduled QA meeting on 3-26-25, that all residents have the potential to be affected by this deficient practice. * On 3-25-25, specific key staff were in serviced, by the DON, to include observing for and removing OTC medications in resident rooms during daily room rounds. * Beginning 3-26-25, the key personnel, that has been assigned rooms to audit on a daily basis will ensure they are reporting on a daily basis any concerns related to medications found in any rooms. This audit is added to the morning meeting report; as a daily item discussed. Upon admission or if resident requests to administer medications after admission, the RN Supervisor will be responsible to	

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M 705	Continued From page 20 the resident had medicine sitting on the overbed table because she gives him all of his medications and stands there while he takes them. During an observation and interview on 3/12/25 at 11:25 AM LPN #4 confirmed that the resident had medications sitting on his overbed table and revealed he was not supposed to have them. She revealed his family brought these medicines in for him, and she had overlooked them sitting there. In an interview on 3/12/25 at 11:35 AM, the Assistant Director of Nurses (ADON) confirmed that Resident #10 did not have a medication self-administration form filled out and had not been evaluated to self-administer medications. She confirmed the medications were not supposed to be left at the bedside, but all medications were to be kept locked in the medication cart. She revealed with the resident having access to these medications, he could take too much, or someone could wander into his room and take them. A record review of Resident #10's "Admission Record" revealed the resident was admitted to the facility on 11/10/2024 with medical diagnoses that included Hypertensive Heart and Chronic Kidney Disease with Heart Failure and Stage 1 through Stage 4 Chronic Kidney Disease, and Gastro-Esophageal Reflux Disease. A record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 12/19/2024 revealed a Brief Interview for Mental Status (BIMS) score of 9, which indicated Resident #10 has moderate cognitive impairment.	M 705	assess whether the resident is able to perform self administration of medications and the ability to keep at bedside via the Self Administration Assessment and a physician order. The Quality Assurance Committee will review each self administration assessment as they occur; with a special called QA meeting or the upcoming one; whichever is the earliest for six (6) weeks then monthly for two (2) months, to ensure compliance. A QA meeting has been scheduled for 3-26-25.	

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	25CR	A. BUILDING: _____ B. WING _____	03/13/2025

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M 815	Continued From page 21	M 815		
M 815	45.29.1 Safe Food Handling Procedures Safe Food Handling Procedures. Food shall be prepared, held, and served according to current Mississippi State Department of Health Food Code Regulations. This Statute is not met as evidenced by: Level II Widespread Based on observation, staff interview, record review, and facility policy review, the facility failed to ensure dietary staff followed proper hand hygiene practices and monitor food temperatures in a manner that prevented cross-contamination for one (1) of two (2) kitchen tours. Findings Include: Review of the facility policy titled "Hand and Single Use Glove Sanitation Practices" with a revision date of October 2017, revealed under, "Policy: Facility employees shall follow sanitary practices when handling food to prevent the spread of foodborne illness..." Review of the facility policy titled "Guidelines for Using Thermometers" with a revision date of October 2017, revealed under, "Policy: the facility shall monitor temperatures of hazardous foods to maintain quality and safety of food served using an appropriate thermometer..." An observation of the kitchen on 3/12/25 at 11:00 AM revealed Dietary Staff #2, located near the 3-compartment sink, gathering kitchen utensils. He walked over to the steam table with a white dish cloth in his hands and began setting up to check food temperatures. Dietary Staff #2 did not wash his hands before proceeding. After	M 815	* On 3-12-25, the Dietary Manager (DM), in-serviced Dietary Staff #2 in regards to the proper hand hygiene using the Nutrition Systems guidance titled, "Hand Washing Importance and Technique". On 3-12-25, the DM also in-serviced Dietary Staff #2 on proper procedures of using thermometers with the Nutrition Systems guidance titled, "Guidelines for Using Thermometers". * All residents receive their meals through the dietary department; therefore, all residents had a potential to be affected by the deficient practice of improper hand hygiene and improper cleaning of the thermometers. * On 3-12-25, the DM began a 100% training in proper hand hygiene and the proper use of the thermometers for all dietary staff. The Quality Assurance Committee were updated on the trainings on 3-26-25 by the DM with no other recommendations being made. * The DM is responsible to in-service current and new dietary employees on the proper hand hygiene and proper usage of the thermometers. On 3-13-25, the DM began auditing dietary staff members	4/18/25

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M 815	Continued From page 22 measuring the temperature of the hamburger patties, he picked up the dish cloth from the plate rest and wiped the end of the thermometer probe. He then inserted the thermometer into a pan containing lettuce and tomatoes. After removing the thermometer, he again wiped the probe with the dish cloth, continuing this same process - checking temperatures and wiping the probe with the dish cloth - until all food temperatures were measured. An interview with Dietary Staff #2 on 3/12/25 at 11:16 AM confirmed that he did not wash his hands before checking the food temperatures. He stated, "I just had my hands in Clorox water," and acknowledged that this practice could cause cross-contamination of the food. He further explained that it was common practice to use a dish cloth to wipe the thermometer probe between uses, and that this was how he had been trained to do it. Dietary Staff #2 admitted that this could potentially make a resident sick due to cross-contamination from the dish towel to the food. An interview with the Dietary Manager (DM) on 3/12/25 at 11:36 AM confirmed that dietary staff were required to perform hand hygiene before checking food temperatures and anytime they handle food. She explained that the kitchen had disposable wipes that should be used to clean the thermometer probe between uses. The DM acknowledged that improper hand hygiene and improper cleaning of the thermometer could result in cross-contamination and the spread of harmful bacteria to food.	M 815	regarding proper hand hygiene and proper usage of the thermometers on various shifts. The DM will continue audits for six (6) weeks; then monthly as an on-going basis. The QA Committee met on 3-26-25 and approved the plan of correction and will receive a report on all non-compliance weekly at the scheduled QA meeting on Wednesdays for six (6) weeks then monthly for two (2) months; then quarterly for two (2) quarters.	
M1570	48.58.1 Infection Control	M1570		4/18/25

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	25CR	A. BUILDING: _____ B. WING _____	03/13/2025

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M1570	Continued From page 23 The following infection control standards shall be met: 1. The facility must maintain and document an effective infection control program that protects patients, families, visitors, and facility personnel by preventing and controlling infections and communicable diseases. 2. The facility must have an active surveillance program that includes specific measures for prevention, early detection, control, education, and investigation of infections and communicable diseases in the facility. There must be a mechanism to evaluate the effectiveness of the program(s) and take corrective action when necessary. The program must include implementation of nationally recognized systems of infection control guidelines to avoid sources and transmission of infections and communicable diseases. 3. The facility must follow accepted standards of practice to prevent the transmission of infections and communicable diseases, including the use of standard precautions. This Statute is not met as evidenced by: Level II Based on observation, resident representative and staff interviews, record review, and facility policy review, the facility failed to ensure proper catheter care and infection control practices were implemented for one (1) of four (4) residents direct care areas observed (Resident #37). Findings include: A review of the facility policy titled, "Catheter Care	M1570	* On 3-13-25, the Assistant Director of Nursing (ADON)/Infection Control Preventionist (ICP), in-serviced CNA #6 on the proper technique for cleaning a foley catheter; and to reiterate the importance of ensuring the urinary bag and tubing does not touch the floor. On same date, the ADON/ICP in-serviced CNA #6 that if the bag or tubing falls to the floor, then she is to inform the assigned nurse or RN Supervisor allowing the tubing and the bag to be changed to decrease the risk of	

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	25CR	A. BUILDING: _____ B. WING _____	03/13/2025

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M1570	Continued From page 24 Urinary," revised September 2014, revealed under Infection Control: b.) Ensure the catheter tubing and drainage bag are kept off the floor. Further review of the policy under Steps in the Procedure revealed: 31.) Use a clean washcloth with warm water and soap/or cleansing wipe to cleanse and rinse the catheter. An observation of Resident #37 and interview with the resident's representative on 3/11/25 at 2:23 PM revealed a catheter bag hanging on the left side of the resident's wheelchair, with the catheter bag and tubing observed resting on the floor. During an interview at that time with the resident's representative, she revealed the resident has a history of frequent urinary tract infections and has the catheter because her bladder does not empty. An observation of catheter care for Resident #37 on 3/12/25 at 10:20 AM revealed upon entrance to the room, the catheter bag and tubing were laying on the floor. Certified Nurse Assistant (CNA)# 6 was observed performing hand hygiene and cleansing the urinary meatus and catheter tubing with a wet washcloth. There was no observation of soap or cleansing products added to the water basin or washcloth. CNA #6 then dried the urinary meatus and catheter tubing with a dry cloth, completed the procedure, and performed hand hygiene. In a concurrent interview, CNA #6 confirmed the catheter bag should not have been placed on the floor. She also acknowledged she cleaned the urinary meatus, perineal area, and catheter tubing using only water without soap or cleansing product. CNA #6 stated she avoided using soap because she did not want to irritate the resident's skin. Record review of the Order Summary Report for	M1570	infection. On, 3-13-24, CNA #6 was in-serviced, by the ADON/ICP, on the proper cleaning agent for catheter care to include, soap and water or a disposable wipe. * The current census has six (6) residents that have orders for catheter care; therefore, six (6) residents had the potential to be affected by this deficient practice. * On 3-12-25, the policy titled, "Catheter Care Urinary" was reviewed and assigned per SNF Clinic Training, by the Director of Nursing (DON) to nursing staff for completion. Beginning on 3-17-25, the ADON/ICP began hands on, return demonstration on catheter care with each nursing employee. On 3-26-25, the DON, in-serviced each employee that is responsible for daily room rounds to observe proper placement of catheter bag and tubing. * On 3-17-25, the ADON/ICP began auditing proper catheter care on four (4) residents per week for six(6) weeks; then four (4) per month; this will be an on going process. The Quality Assurance (QA) Committee will receive a report on any non-compliance weekly in the already scheduled QA meeting each Wednesday for six (6) weeks; then monthly for two (2) months; quarterly thereafter on an ongoing basis. This was implemented during the QA meeting that was held on 3-26-2025.	

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M1570	Continued From page 25 Resident #37 revealed an active order dated 1/29/25 to clean urinary catheter with soap and water every shift. During an interview with the Director of Nursing (DON) on 3/12/25 at 11:14 AM, she confirmed the catheter bag should not have been placed on the floor and that staff performing catheter care should have used soap and water to clean Resident #37 as ordered. She stated that placing the catheter bag on the floor and failing to cleanse with soap and water increases the risk of infection for the resident. Record review of Resident #37's "Admission Record" revealed the resident was admitted on 1/29/25 with diagnoses including Urinary Retention and Urinary Tract Infection. Record review of Resident #37's Minimum Data Set (MDS), Section C, with an Assessment Reference Date (ARD) of 2/5/25, revealed a Brief Interview for Mental Status (BIMS) score of 5, indicating severe cognitive impairment. Section H-Bladder and Bowel was coded as having an indwelling catheter.	M1570		