| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| **PARKWAY HEALTH & REHAB LLC** | **230 RIVER OAKS DRIVE CANTON, MS 39046** |

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| F 000 | INITIAL COMMENTS<br><br>The State Agency (SA) conducted a Complaint Investigation (CI MS #27756) at the facility on 2/03/25. During the survey, the SA determined the facility was not in compliance with the requirements for participation in Medicare and Medicaid. The SA investigated CI MS #27756 for Quality of Care/Treatment, pressure ulcers, and injury of unknown origin and cited F 657 and F 686.<br><br>At the time of survey the facility had a census of 75 residents and was licensed for 87 beds. | F 000 | | |
| F 657 SS=G | Care Plan Timing and Revision<br>CFR(s): 483.21(b)(2)(i)-(iii)<br><br>§483.21(b) Comprehensive Care Plans<br>§483.21(b)(2) A comprehensive care plan must be-<br>(i) Developed within 7 days after completion of the comprehensive assessment.<br>(ii) Prepared by an interdisciplinary team, that includes but is not limited to--<br>(A) The attending physician.<br>(B) A registered nurse with responsibility for the resident.<br>(C) A nurse aide with responsibility for the resident.<br>(D) A member of food and nutrition services staff.<br>(E) To the extent practicable, the participation of the resident and the resident's representative(s).<br>An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan.<br>(F) Other appropriate staff or professionals in disciplines as determined by the resident's needs | F 657 | | 2/25/25 |

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| Electronically Signed | | 02/17/2025 |

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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| F 657 | Continued From page 1<br>or as requested by the resident.<br>(iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.<br>This REQUIREMENT is not met as evidenced by:<br>Based on complainant and staff interview, record review and facility policy review, the facility failed to revise a pressure risk care plan for a resident who developed a pressure ulcer for one (1) of (3) three residents care plans reviewed. (Resident #1)<br><br>Findings include:<br><br>Review of the facility policy titled, "Care Plans, Comprehensive Person-Centered," with no revision date revealed, "Policy Interpretation and Implementation: ...13.) Assessments of residents are ongoing, and care plans are revised as information about the residents and the residents' conditions change..."<br><br>Record review of Resident #1's care plan titled "Resident is a risk for pressure ulcers/further impaired skin integrity related to (r/t) incontinence dementia," with onset date of 12/11/24 and revision date of 1/27/25, revealed no revisions to the care plan prior to the onset of the deep tissue injury (DTI) identified on 1/19/25.<br><br>On 1/31/25 at 4:00 PM, during a phone interview with the complainant, she revealed her mom (Resident #1) was sent to the hospital on 1/19/25 and was assessed to have an open pressure ulcer on her right heel that was black and draining. She then stated cannot understand how a wound on her foot that was open, black in color | F 657 | *On 2-4-25, the Director of Nursing (DON), reviewed Resident #1 care plan to ensure proper interventions were in place for her current medical status; to include the pressure injury to right heel. The care plan had been updated to include interventions to prevent decline of the pressure injury upon re-admit from hospital. The interventions were appropriate with the problem, goal and interventions.<br><br>*On 2-4-25, the DON reviewed residents with a change of condition with four residents identified. The four residents identified possibly could have been affected.<br><br>*On 2-13-25, the Quality Assurance (QA) Committee reviewed the policy title: Care Plans, Comprehensive Person-Centered. The QA Committee found the policy to be without any need for revisions. The QA Committee made recommendation for all concerns listed in the Stop and Watch Program to be reviewed daily during the daily clinical meeting and care plans be revised at that time by the Minimum Data Set (MDS) Nurse. This will continue on a daily basis as an on-going process to ensure the care plans are updated timely and accurately. On 2-13-25, the DON did | |

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| F 657 | Continued From page 2 | F 657 | | |

and draining had not already been identified and addressed.

Record review of Resident #1's hospital notes dated 1/19/25 confirmed that the resident presented to the hospital on 1/19/25 at 10:23 PM with a pressure injury of deep tissue injury (DTI) with epithelial separation, revealing partial thickness pink wound bed with deep purple discoloration, scant drainage, and devitalized tissue surrounding wound noted to right heel on initial wound care exam.

On 2/3/25 at 10:30 AM, an interview with the Director of Nursing (DON) confirmed that the pressure risk care plan should have been revised when the resident had a decline in function increasing her pressure ulcer risk and any new interventions should have been put in place for pressure prevention. She stated that she had determined after the resident was transferred to the hospital that she had a decline for approximately two weeks prior in her activities of daily living (ADL) function that included mobility and self-feeding. She revealed that she reviewed the residents Kardex, and it did not reflect any pressure reducing measures in place prior to the onset of the pressure injury to the right heel.

Record review of the Minimum Data Set (MDS) Kardex Report for Resident #1 dated 12/11/24 revealed no revisions to the Kardex related to skin and ulcer treatment.

On 2/3/25 at 11:00 AM, during an interview with the MDS Nurse she confirmed that since Resident #1 showed a decline in her ADL function and nutrition then she was at a higher risk for pressure injury and extra precautions should

100% audit on all care plans for residents with wounds with none being found to need revisions. The treatment nurse will be responsible to update wound and/or treatment care plans as new orders occur or changes in skin integrity appear; these changes will be reviewed daily during the clinical meeting. This will be an on-going process. The Interdisciplinary Team will audit each care plan during the quarterly, comprehensive and significant change assessments.

*Any identified non-compliance will be presented to the QA Committee for recommendations. The non-compliance will be presented by the DON with a special QA Committee Meeting being scheduled or at the next regularly scheduled QA meeting; whichever date is the earliest possible. The DON began with body audits on 2-5-25. These audits will be presented to the QA Committee at the scheduled meeting for 2-24-25. Regular oversight of the care plan process will be reviewed by the QA Committee each quarter going forward. The DON began audits of a minimum of four charts for four weeks on 2/11/25; then monthly for two months to determine compliance of updating the care plans timely and accurately.

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| F 657 | Continued From page 3<br>have been put in place to reduce the risk. She confirmed that the residents care plan had not been revised after that decline or prior to the return from the hospital with the onset of the pressure injury. She revealed the purpose of the care plan is to inform staff of the specific resident care needed to care for that resident.<br><br>Review of the "Admission Record" revealed Resident #1 was admitted by the facility on 12/11/24 with diagnoses that included Unspecified Dementia and Aphasia. | F 657 | | |
| F 686 SS=G | Treatment/Svcs to Prevent/Heal Pressure Ulcer<br>CFR(s): 483.25(b)(1)(i)(ii)<br><br>§483.25(b) Skin Integrity<br>§483.25(b)(1) Pressure ulcers.<br>Based on the comprehensive assessment of a resident, the facility must ensure that-<br>(i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and<br>(ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing.<br>This REQUIREMENT is not met as evidenced by:<br>Based on complainant, resident representative and staff interviews, record review, and facility policy review, the facility failed to provide necessary services to prevent new pressure ulcers from developing for one (1) of three (3) residents with wounds reviewed. (Resident #1) | F 686 | *On 2-4-25, the Director of Nursing, (DON) reviewed Resident #1 wound care orders and care plan to ensure proper wound care protocol and policy were being followed. No issues were identified with the hospital return orders and care plan. | 2/25/25 |

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| F 686 | Continued From page 4<br>Findings include:<br><br>Review of the facility policy titled, "Prevention of Pressure Ulcers/Injuries," with no revision date, revealed, "Purpose: The purpose of this procedure is to provide information regarding identification of pressure ulcer/injury risk factors and interventions for specific risk factors." ...<br><br>In a phone interview with the complainant on 1/31/25 at 4:00 PM, she revealed her mom (Resident #1) was sent to the hospital on 1/19/25 and was assessed to have an open pressure ulcer on her right heel that was black and draining. She stated she was concerned because Resident #1 had started declining about a week before being sent to the hospital, requiring increased assistance with all her care and transfers. She then revealed she also cannot understand how a wound on her foot that was open, black in color and draining had not already been identified and addressed. The complainant admitted that the only thing that staff put on Resident #1's feet prior to the discovery of the wound were socks and her heels were never floated or had foot pillows.<br><br>Record review of the hospital notes dated 1/19/25 revealed Resident #1 presented to the hospital on 1/19/25 at 10:23 PM with a deep tissue injury (DTI) with epithelial separation, revealing partial thickness pink wound bed with deep purple discoloration, scant drainage, and devitalized tissue surrounding wound noted to right heel on initial wound care exam.<br><br>During an interview with Resident #1's Representative on 2/3/25 at 10:20 AM, he stated that he visits with his wife (Resident #1) for | F 686 | *On 2-5-25, the assigned license practical nurse (LPN) and registered nurse (RN) performed a 100% body audit on the residents that reside on the unit where the resident resided. No other residents were found to have any unknown skin concerns. However, the residents that are non-verbal or non ambulatory had the possibility to be affected, the number of these residents are 16.<br><br>*On 2-4-25, the DON implemented a Stop and Watch Program with emphasis on pressure ulcer prevention and change of conditions. This program has the purpose to ensure timely and accurate communication between staff members. The DON began in-services for all staff members to implement knowledge of said program on 2-4-25. On 2-5-25, the Policy titled Prevention of Pressure Ulcers was reviewed by the Quality Assurance Committee and it was determined no revisions needed to be made.<br><br>*The Registered Nurse (RN) Supervisor will be responsible to check the Stop and Watch Program binder and ensure any concerns are relayed to proper staff member for timely follow up, on a daily basis. The DON will receive a copy of all concerns placed in the Stop and Watch binder; then weekly the DON will follow up to ensure timely communication and interventions are completed. This will be on ongoing process. Each quarter the DON will present a report to the QA committee for review of the program for | |

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| F 686 | Continued From page 5<br>several hours every day, and he had noticed that over a week prior to being sent to the hospital, she kept leaning to the left in the wheelchair. He stated she stopped feeding herself and had to be fed and required more assistance from staff for toileting and transfers. He admitted that he could not physically assist her anymore because she was unable to help at all. He stated he was not aware of any wound on her foot until the nurse who called about her going to the hospital said she had a blister on her right heel. The Resident Representative confirmed that he had never seen Resident #1's heels floated, foot pillows or any kind of positioning device used for her prior to the wounds being discovered and that the only thing that was ever on his wife's feet were socks.<br><br>In an interview with the Director of Nursing (DON) on 2/3/25 at 10:30 AM, confirmed that it was determined that Resident #1 showed a decline in function approximately two weeks before being sent to the hospital on 1/19/25. She stated the resident was mobile short distances with staff assistance and limited on standing with assistance upon admission but declined requiring two staff members assistance for transfers, toileting, and bed mobility. She then stated she was informed by staff on 1/19/25 at the time of transfer to the hospital that the resident had a blister on her right heel. Furthermore, she stated there was no documentation in the medical record of the wound before that date. She stated she was not informed that the wound was dark purple/black in color and open and draining. The DON revealed when the resident began declining in Activities of Daily Living (ADL) function and requiring more assistance with care, she was at a higher risk for pressure injury and should have had resident specific interventions put in place. | F 686 | effectiveness and to make recommendations for revisions if needed. Weekly body audits will be completed by the assigned nurse to identify any skin concerns; the DON will audit the body audits weekly by performing two body audits after assigned nurse has to ensure compliance, this began on 2-4-25.<br><br>Any identified non-compliance will be presented to the QA Committee for recommendations. The non-compliance will be presented by the DON with a special QA Committee Meeting being scheduled or at the next regularly scheduled QA meeting; whichever date is the earliest possible. The current audits being performed will be presented to the QA Committee at the scheduled meeting on 2-24-25. | |

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| F 686 | Continued From page 6 | F 686 | | |

She confirmed, after review of Resident #1's medical record, she could not find where any resident specific interventions were put in place to reduce the risk of pressure injury and that could have led to the development of a pressure injury.

Record review of the Active Order Summary Report dated 1/20/25 for Resident #1 revealed no orders related to skin or pressure relief prevention.

In an interview with Licensed Practical Nurse (LPN)#1 on 2/3/25 at 10:50 AM, she revealed she had cared for Resident #1 several days over the few weeks before she went to the hospital and noticed that the resident had been leaning in the wheelchair. She confirmed that the resident had to be fed and required more care by staff for transfers, toileting, and mobility. She also confirmed that the resident did not wear foot pillows or have orders to float heels prior to the discovery of the wound.

In an interview with Certified Nurse Assistant (CNA) # 1 on 2/3/25 at 10:50 AM confirmed that Resident #1 had started declining a couple of weeks ago requiring two staff members to assist with transfers and toileting because the resident had quit assisting with pivoting, no longer ambulating or following simple direction. She also stated she was no longer feeding herself or repositioning herself.

In an interview with the Minimum Data Set (MDS) Nurse on 2/3/25 at 11:00 AM she revealed she was not aware that Resident #1's condition had declined before her hospital stay, but confirmed if she was no longer ambulating, declined in ADL function, and nutrition then she was at a higher

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| F 686 | Continued From page 7 | F 686 | | |

risk for pressure injury and extra precautions should have been put in place to reduce the risk. She then confirmed that their failure to put interventions in place could have led to the development of the pressure ulcer.

In an interview with LPN #2 on 2/3/25 at 11:30 AM, she revealed she assisted LPN #3 get Resident #1 ready to transfer to the hospital on 1/19/25. She stated they both were working 7:00 AM-7:00 PM that day and did observe an open dark purple/blackish blister area to the resident's right heel that she would have considered to be one-half (½) dollar in size. She confirmed the resident only had socks on her feet, heels were not floated, and no heel protectors were on.

In an interview with LPN #3 on 2/3/25 at 11:50 AM revealed she was assigned Resident #1 on 1/19/25 when she was sent to the hospital. She stated during her assessment; she observed an open draining dark purple blistered area with dried drainage noted to the resident's right sock and her fitted sheet of the bed. She stated she had never been informed of the wound before, but stated, "it was obvious from the condition of the wound that it did not just form." She then stated she would say the size was about the size of a half dollar.

In an interview with CNA #2 on 2/3/25 at 3:00 PM, confirmed that Resident #1 had needed additional assistance from staff over the past few weeks, because she was no longer able to assist with her care. She confirmed that the resident was leaning in the wheelchair and would not move unless staff assisted her, which was different from her norm. She stated that she had never seen a wound on the resident's foot, stating she always had socks

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| F 686 | Continued From page 8<br>on, and confirmed the resident did not have any foot pillows in her room.<br><br>Record review of Resident #1's "Admission Record" revealed the facility admitted the resident on 12/11/24 with medical diagnoses that included Unspecified Dementia and Aphasia. | F 686 | | |