MSDH - Health Facilities Licensure and Certification

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 _____	C 02/03/2025

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 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 Minimum Standards for Institutions for the Aged or Infirm, state licensure requirements .The SA investigated CI MS #27756 for Quality of Care/Treatment, pressure ulcers, and injury of unknown origin and cited M 615. At the time of survey the facility had a census of 75 residents and was licensed for 87 beds.	M 000		
M 615 SS=G	45.21.3 Pressure sores Pressure sores. Residents with a pressure sore shall receive necessary treatment and service to promote healing and prevent the development of new pressure sores. Residents without pressure sores will not develop pressure sores unless the residents' clinical condition indicates they were unavoidable. This Statute is not met as evidenced by: 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) Findings include: 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." ...	M 615	*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. *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	2/25/25

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 _____	C 02/03/2025

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 615	Continued From page 1 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. 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. 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 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	M 615	affected, the number of these residents are 16. *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. *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 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.	

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 _____	C 02/03/2025

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 615	Continued From page 2 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. 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. 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.	M 615	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.	

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 _____	C 02/03/2025

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 615	Continued From page 3 In an interview with the Minimum Data Set (MDS) Nurse on 2/5/25 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 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 Licensed Practical Nurse (LPN)#1 on 2/2/25 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 2/2/25 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 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	M 615		

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 _____	C 02/03/2025

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 615	Continued From page 4	M 615		

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 on, and confirmed the resident did not have any foot pillows in her room.

In an interview with LPN #2 on 2/5/25 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 2/5/25 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.

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.

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 _____	C 02/03/2025

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 615	Continued From page 5 Level III Based on complainant, resident representative	M 615		

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 _____	C 02/03/2025

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 615	Continued From page 6	M 615		

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)

Findings include:

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." ...

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.

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

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 _____	C 02/03/2025

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 615	Continued From page 7 initial wound care exam. 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 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. 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	M 615		

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 _____	C 02/03/2025

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 615	Continued From page 8	M 615		

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. 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

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 _____	C 02/03/2025

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 615	Continued From page 9	M 615		

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 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.

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 _____	C 02/03/2025

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 615	Continued From page 10 She stated that she had never seen a wound on the resident's foot, stating she always had socks on, and confirmed the resident did not have any foot pillows in her room. 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.	M 615		