

MSDH - Health Facilities Licensure and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 25CR	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R-C 02/26/2025
NAME OF PROVIDER OR SUPPLIER PARKWAY HEALTH & REHAB LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 230 RIVER OAKS DRIVE CANTON, MS 39046		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{M 000}	Initial Comments The State Agency (SA) conducted a revisit survey at the facility on 2/26/25 related to the complaint survey that was conducted on 1/14/25. During the survey, the SA determined the facility had put measures in place to correct deficient practice with the requirements of the Mississippi Regulations for Minimum Standards for Institutions for Aged or Infirm as of 2/7/25. However, the facility remains out of compliance due to deficiencies cited on the 2/3/25 complaint survey. The facility achieved compliance on 2/25/25. At the time of the survey the facility census was 77 with a bed capacity of 87 beds.	{M 000}		

Mississippi State Department of Health

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

TITLE

(X6) DATE

Electronically Signed

03/03/25