STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255273	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 02/26/2026

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	INITIAL COMMENTS The State Agency (SA) conducted an Annual Recertification survey at the facility from 02/23/2026 through 02/26/2026. During the survey, the SA determined the facility was not in compliance with the requirements of participation in Medicare and Medicaid and cited F657, F684, F800 and F880. The facility was licensed for 87 beds and had a census of 76.	F0000		
F0656 SS = D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the	F0656		

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 reverse for further 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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F0656 SS = D	Continued from page 1 resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, record review and facility policy review, the facility failed to implement the comprehensive person-centered care plan by not maintaining Enhanced Barrier Precautions (EBP) during care for one (1) of three (3) residents reviewed for infection control practices. Resident #9. Findings include: Record review of the facility policy "Care Plans Comprehensive Person-Centered" revised December 2016 revealed “A comprehensive person-centered care plan that includes measurable objectives, and timetables to meet the resident's physical psychosocial and functional needs is…implemented for each resident…” Record review of the “Care Plan Report” with a revision date of 1/13/26 revealed “Focus…Resident is NPO (nothing by mouth) gastrostomy tube…Interventions/Tasks…Maintain Enhanced Barrier Precautions…” On 2/24/26 at 1:20 PM, during an observation, Licensed Practical Nurse (LPN) #2 performed Percutaneous Endoscopic Gastrostomy (PEG) tube site care for Resident #9 without donning a gown prior to initiating care. On 2/24/26 at 1:26 PM, during an interview, LPN #2 reported she forgot to apply a gown prior to performing PEG tube care. She acknowledged the facility uses a	F0656		

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F0656 SS = D	Continued from page 2 green dot indicator on the door name tag to remind staff to wear gowns for care and stated that following Enhanced Barrier Precautions helps prevent the spread of infection during direct contact care. On 2/25/26 at 2:30 PM, during an interview, the Infection Prevention (IP) Nurse reported the purpose of Enhanced Barrier Precautions is to prevent transmission of bacteria between staff and residents and stated failure to wear required personal protective equipment (PPE) can contribute to the spread of infection. On 2/26/26 at 11:30 AM, during an interview, the Director of Nursing (DON) stated she is responsible for ensuring care plans are developed and implemented. She reported that failure to follow the care plan intervention to maintain Enhanced Barrier Precautions could increase the risk of infection transmission and stated it is her expectation that staff follow care plans as written. A record review of the “Admission Record” revealed the facility admitted Resident #9 on 10/8/20 with diagnoses that included Alzheimer’s Disease with early onset. A record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 11/26/25 revealed Resident #9 was unable to complete a Brief Interview for Mental Status (BIMS) due to cognitive impairment.	F0656		
F0684 SS = D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is NOT MET as evidenced by: Based on interview and record review, the facility failed to provide necessary care and services in accordance with professional standards of practice to address abdominal distention and fecal burden in a timely manner, which resulted in hospitalization for fecal impaction for one (1) of three (3) residents reviewed for hospitalization. Resident #56.	F0684		

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F0684 SS = D	Continued from page 3 Findings include: Record review of “Radiology Interpretation” dated 11/28/25 revealed “…Impression: Acute process. Mild fecal loading…” A record review of an XR (x-ray) Abdomen 1 view” report dated 12/22/25 revealed “…Impression…2. Moderate gaseous distention of the small bowel, unchanged in comparison with the prior. Record review of the “CT (computer tomography) Abdomen WO (without) Pelvis” dated 12/22/25 revealed “Impression: 1. Large fecal burden with findings suggesting stercoral proctitis…” Record review of the December 2025 Medication Administration Record (MAR) revealed Dulcolax suppositories had been administered on 12/10/25 and 12/24/25. Lactulose was also administered on 12/25/26, 12/26/26 and 12/27/26. There was no documentation of preventive bowel medications following CT findings of fecal burden on 12/22/25. Record review of the “Hospital Course” with an encounter date of 12/27/25 revealed “CT chest abdomen and pelvis showed rectal fecal impaction with perirectal stranding concerning for stercoral colitis with large colonic fecal burden…” On 2/24/26 at 9:24 AM, during a telephone interview, the resident’s brother reported he was upset when he learned the resident had to be hospitalized for constipation and stated he felt the facility “let him get stopped up.” On 2/25/26 at 3:30 PM, during an interview, the Director of Nursing (DON) reported the resident was receiving Colace and Miralax for bowel function and had bowel movements on 12/21/25 and 12/22/25. She stated the resident developed abdominal distention and imaging was completed. She reported CT results were not available and reviewed by staff until 12/24/25. She confirmed the resident was hospitalized on 12/27/25 after blood sugar dropped and further evaluation revealed fecal impaction. On 2/26/26 at 10:27 AM, during an interview, the DON reported the resident began facial grimacing and abdominal tenderness on 12/10/25 and Dulcolax was administered. She confirmed the resident continued to have bowel movements during this period.	F0684		

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F0684 SS = D	Continued from page 4 On 2/26/26 at 11:30 AM, during an interview, the Nurse Practitioner reported the resident was not placed on routine preventive bowel medication because he had no prior history of constipation. She stated residents are typically placed on preventive medications when receiving pain medications. She acknowledged that although CT results may sometimes be available the same day, results are occasionally delayed. She stated that earlier treatment could have benefitted the resident but indicated she initially suspected a urinary tract infection rather than bowel issues due to clinical presentation. On 2/26/26 at 11:40 AM, during an interview, medical records staff reported CT results are typically available the same day or by the following day and acknowledged the results from 12/22/25 were not retrieved until 12/24/25. She stated she was unsure why there was a delay. On 2/26/26 at 12:39 PM, during a follow-up interview, the DON reported the facility does not have a specific hospitalization prevention policy and follows Centers for Medicare and Medicaid Services (CMS) critical pathway guidance. She stated that because CT findings on 12/22/25 showed mild fecal burden and treatment was not initiated until 12/24/25, it was possible the subsequent hospitalization on 12/27/25 for fecal impaction could have been prevented. A record review of the “Admission Record” revealed the facility admitted Resident #56 on 1/24/20 with diagnoses including Cerebrovascular Accident (CVA) and Acute Respiratory Failure with Hypoxia. A record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 12/27/25 revealed Resident #56 had a Brief Interview for Mental Status (BIMS) score of zero (0), which indicated the resident’s cognition was severely impaired. Documentation noted the BIMS was unable to be completed due to mental impairment and aphasia.	F0684		
F0800 SS = D	Provided Diet Meets Needs of Each Resident CFR(s): 483.60 §483.60 Food and nutrition services. The facility must provide each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs, taking into consideration the preferences of each resident.	F0800		

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F0800 SS = D	Continued from page 5 This REQUIREMENT is NOT MET as evidenced by: Based on observation, interviews, record review and facility policy review, the facility failed to ensure that dietary staff support and respect a resident's right to make choices about his or her meal preferences for two (2) of (18) sampled for Residents reviewed for food preferences. Resident #45 and #47. Findings include: A review of the facility policy, "Dietary Preference & Nutritionally Accuracy" undated, revealed, "Objective: To ensure the Dietary Department provides meals that align with each resident's personal tastes...3. "2...Menu Substitution Log: If a resident expresses a new dislike, the DM must update their Permanent Profile and ensure the production staff is notified of the change to avoid food waste." Resident #45 During an interview with Resident #45 on 2/23/26 at 11:15 AM, she shared her worries about her current dietary preferences not considered in light of her diabetes diagnosis. For her, managing blood sugar levels is essential, and it has been quite frustrating that the meals provided at the facility do not match her dietary preferences. While she mentioned that medication can help control her condition, she pointed out that at home, she avoided starchy, high-carbohydrate foods, and she would like to maintain that practice here as well. Resident #45 remarked that at lunchtime and dinnertime, her meals often include rice and potatoes, which she tries to avoid because they tend to spike her blood sugar. For breakfast today, she said her tray included a blueberry muffin and grits. She mentioned that the typical breakfast options usually include waffles, pancakes, biscuits, or muffins. Despite raising her dietary concerns several times to the Dietary Manager who visited her room, the manager only responded with “We’ll work on it,” without any noticeable improvements. Additionally, her meal ticket hasn’t been updated to reflect her preferences, which results in trays that overlook her food choices and dietary needs. She then pointed to her lunch tray, just delivered, and said, “Look at this. It has red beans, sausage, and a huge helping of white rice.” She added, “I simply can’t eat the rice.” During an observation of the lunch meal tray on 2/23/26 at 11:19 AM, the SA confirmed Resident #45 had beans, sausage, and a large amount of white rice.	F0800		

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F0800 SS = D	Continued from page 6 A record review of the meal ticket for Resident #45 on 2/23/26 and 2/24/26 revealed there are no likes or dislikes referencing dietary preferences on the tray card. In an interview on 2/25/26 at 11:35 AM, the Dietary Manager, stated that residents had never mentioned concerns to her about meals being high in carbohydrates or not meeting their dietary preferences. She acknowledged, however, that she has gone to speak with Resident #45 several times because the resident “has made many complaints,” though she reported the concerns were mainly about her tea being sweet when she has asked for unsweetened. The DM further admitted that the resident’s current meal ticket does not list any preferences because it has been “a few months” since she last updated it. She stated that the meal ticket should reflect each resident’s likes, dislikes, and preferences, and that these preferences should be honored at every meal During an interview with Certified Nursing Assistant (CNA) #1 at 12:36 PM on 2/25/26, confirmed that she has worked with Resident #45. She mentioned that Resident #45 frequently expresses concerns about her meals, specifically stating that she doesn’t want to eat certain foods because of their impact on her blood sugar levels. CNA#1 noted that she informs the dietary staff whenever the resident voices these preferences. However, she explained that even though the dietary staff responds with a simple "ok," this feedback doesn’t make it onto the tray card. As a result, each day, the kitchen continues to send meals that the resident dislikes, forcing her to repeatedly notify the staff about the mismatched orders. "This ongoing cycle never seems to end." A record review of the "Admission record" reveals the facility admitted the Resident #45 on 11/24/25 with diagnosis including Type 2 Diabetes Mellitus with Other Specified Complications and Essential (Primary) Hypertension. A record review of the Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 1/28/26 revealed a Brief Interview Mental Score (BIMS) summary score of (15) indicating the resident is cognitively intact. Resident #57 On 2/23/26 at 12:47 PM, during an interview, Resident #57 expressed her preference for eating in her room. She shared her concerns about the meals provided by the	F0800		

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F0800 SS = D	Continued from page 7 kitchen, stating that they don't accommodate her dietary needs given her current diagnosis. She feels that the staff hasn't informed her about her options to choose different items or healthier alternatives, leaving her feeling trapped with the meals she's served. She noted that the posted menus don't mention any alternatives available to her. For instance, she recalled being served red beans and rice for lunch. While she felt the rice was unnecessary for her diet, she had no better choices and had to eat it anyway. For breakfast, grits are offered, which she simply doesn't enjoy. She voiced her desire for more consistent and appropriate meal options that she could actually look forward to. On 2/24/26 at 8:07 AM, during a follow-up interview, Resident #57 shared details about her dinner. She mentioned that it included butter beans and corn, expressing concern that any of the vegetables should typically be served to someone with her diagnosis. Despite feeling this way, she admitted she ate them anyway, feeling that the kitchen often fails to provide consistent, healthier options. During an observation of the breakfast tray on 2/24/26 at 8:09 AM, the SA observed Resident #57 was served grits and a biscuit. A record review of the breakfast tray card on 2/24/26 revealed no likes or dislikes that reflect dietary preferences. During a phone interview with the Dietitian on 2/24/26 at 11:52 AM, it was stated that resident preferences are important. The kitchen should strive to avoid placing undesired items on their trays and make necessary adjustments, as long as they fall within dietary guidelines. Furthermore, it's essential to ensure that the tray card is updated to accurately reflect these preferences. On 2/25/26, at 12:00 PM, the Dietary Manager shared some insights during a brief interview. She mentioned that the menus are displayed on the television hanging on the wall before entering the dining area. While viewing the television with the SA, the Dietary Manager confirmed that no alternative options were displayed on the screen and admitted she was unaware of this issue. On 2/25/26, at 12:28 PM, Licensed Practical Nurse #1 (LPN) was interviewed and confirmed that she occasionally works with Resident #57. During the interview, she shared that Resident #57 often worries that the meals she receives will cause her blood sugar	F0800		

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F0800 SS = D	Continued from page 8 to spike. The resident has expressed concerns that the kitchen does not offer options that align with her dietary preferences. LPN #1 mentioned that she tries to reassure the resident, telling her that if her blood sugar does increase, she'll be ready to administer her medication. She also noted that this issue has been communicated to the kitchen staff multiple times, yet no changes have been made to address the residents' concerns. A record review of the "Admission record" reveals the facility admitted Resident #57 on 11/24/25 with diagnosis including Type 2 Diabetes Mellitus with Other Specified Complications and Essential (Primary) Hypertensive Heart Disease without Heart Failure. A record review of the MDS with an ARD of 12/1/25 revealed a BIMS summary score of (11) indicating the resident has moderate cognitive impairment.	F0800		
F0880 SS = E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify	F0880		

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F0880 SS = E	Continued from page 9 possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, record review, and facility policy review the facility failed to follow infection prevention and control practices during medication administration and Enhanced Barrier Precautions (EBP) for two (2) of three (3) residents	F0880		

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F0880 SS = E	Continued from page 10 observed for infection control practices. (Resident #9 and Resident #81). Findings include: A record review of facility policy “Enhanced Barrier Precautions” undated, revealed, "Enhanced barrier precautions (EBPs) are utilized to prevent the spread of multi- drug-resistant organisms (MDROs) to residents..." Record review of the facility policy “Infection Prevention and Control” with a revision date of December 2023 revealed “The facility adopted infection prevention and control policies and procedures…to help prevent and manage transmission of diseases and infections…” Record review of the medication "Procedure Guideline" provided by the facility did not provide specific instructions on infection control.Resident # 9At 1:20 PM on 2/24/26, during an observation, Licensed Practical Nurse (LPN) #2 was observed performing percutaneous endoscopic gastrostomy (peg) tube site care for Resident #9. Prior to performing care, LPN#2 failed to don (put on) a gown. In an interview at 1:26 PM on 2/24/26, LPN #2, stated that she forgot to don a gown prior to admission but noted that the facility had a green dot in place on the door name tag to remind staff to wear gowns for care. She stated following EBP would prevent spreading infection to the peg tube site which is susceptible to infection when performing care that requires direct contact On 2/25/26 in an interview with facility Infection Preventionist (RN#1) at 2:30 PM, she stated the purpose of EBP was to prevent staff and residents from catching infection and to keep the staff from transferring infection to another room. She further stated that not wearing Personal Protective Equipment (PPE) as specified in the facility policy can lead to the transfer of bacteria from one resident to another and cause infection and other issues. On 2/26/26 11:30 AM in an interview with the Director of Nursing (DON) she stated that not wearing a gown to follow EBP leads to increased risk of spreading infection and that the importance of EBP is to prevent spreading infection from staff to the residents. It is her expectation that staff follow EBP guidelines as instructed by facility policy. A record review of Resident #9's "Admission Record" revealed she was admitted 10/8/20 with diagnoses that included Alzheimer's disease with early onset A record review of Resident #9's Minimum Data Set (MDS) with an Assessment review Date (ARD) of 11/26/25 revealed she was unable to complete a Brief Interview for Mental Status (BIMS) assessment to determine mental status. Section K of the	F0880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255273	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 02/26/2026

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PARKWAY HEALTH & REHAB LLC	**230 RIVER OAKS DRIVE , CANTON, Mississippi, 39046**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0880 SS = E	Continued from page 11 MDS revealed the resident had an enteral feeding tube.Resident # 81 On 02/25/2026 at 8:37 AM, during a medication administration observation, observed LPN #1 with Resident # 81. During the medication administration, LPN #1 placed medications fluticasone (Nasal Spray) and inhaler (Budesonide) on the bedside table without disinfecting or using a barrier. She then placed those medications back on the cart without disinfecting their packages. In an interview at 8:41 AM on 2/25/26 with LPN #1, she stated she should have disinfected the surface of the bedside table before placing medications on the bedside table or used a barrier to place them on during medications to avoid spreading infection to other residents as the items went directly from a contaminated surface back to the medication cart. In an interview with the Infection Preventionist/ RN#1 on 2/25/26 at 2:30 PM, she stated LPN #1 should have either wiped off the bedside table with disinfectant prior to medication administration She stated that placing the medications on the contaminated bedside table and then placing the medications back on the cart without being disinfected would cause germs to be spread because germs from the nasal cavity and the mouth in the case of the inhaler are being spread then to other residents. In an interview with the DON at 1:05 PM on 2/26/26, she stated that LPN #1 should have wiped off the table and used a barrier prior to medication administration to and not placed the contaminated medications back on the medication cart without disinfecting to prevent the spread of infection. She stated that the nurse in this instance should have disinfected the medication packages before placing on the medication cart with other resident's drugs. A record review of the "Admission Record" revealed Resident #81 was admitted on 2/16/26 with diagnoses that included influenza due to identified novel influenza A virus with pneumonia. A record review of the "Order Summary Report" revealed an order dated 2/16/26 for Budesonide-Formoterol Fumarate Inhalation Aerosol 160-4.5 MCG/ACT (microgram/actuation) two (2) puffs inhale orally every twelve (12) hours rinse and spit after each use and an order dated 2/16/26 for Fluticasone 50mg/ACT (milligram/actuation) propionate two (2) sprays in each nostril one time a day.	F0880		

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