Mississippi State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(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
M0000	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 Minimum Standards for Institutions for the Aged or Infirm, state licensure requirements and cited M1570.	M0000		
M1570	48.58.1 Infection Control 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 LICENSURE 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	M1570		

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

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M1570	Continued from page 1 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 # 9 At 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.	M1570		

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M1570	Continued from page 2 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 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	M1570		

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M1570	Continued from page 3 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.	M1570		