STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255273	A. Building B. Wing	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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0657 Level of Harm - Actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. 47157 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) Findings include: 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 . 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. 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 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. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255273	A. Building B. Wing	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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0657 Level of Harm - Actual harm Residents Affected - Few	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 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. 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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255273	A. Building B. Wing	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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. 47157 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. 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 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. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255273	A. Building B. Wing	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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Actual harm Residents Affected - Few	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. 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 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 (1/2) 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. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255273	A. Building B. Wing	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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Actual harm Residents Affected - Few	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 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.