STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145841	A. Building B. Wing	04/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Parkway Manor	3116 Williamson County Parkway Marion, IL 62959

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32765 Based on observation, interview, and record review the facility failed to ensure call lights were within reach for 8 of 12 (R1-R5, R8, R10, and R11) residents reviewed for call lights in the sample of 12. Findings Include: 1. R1's Resident Face Sheet with a print date of 4/22/25 documents R1 was admitted to the facility on [DATE] and discharged on [DATE] with diagnoses that include aftercare following a joint replacement of left total knee, heart failure, diarrhea, depression, and weakness. R1's Care Plan documents a Problem area with a start date of 4/9/25 of, Ambulation Program- x (times) 1 assist using walker. This same Care Plan documents a Problem area with a start date of 4/8/25 of (R1) is at risk for falls r/t (related to) reduced independent mobility, recent L (left) total knee done, use of psychotropic medication, use of diuretic medication, DX (diagnosis) of osteoarthritis . This Problem area includes the intervention dated 4/8/25 of, Instruct (R1) to call for assist before getting out of bed or transferring. Encourage her to stand slowly. On 4/21/25 at 12:34 PM, V22 (Family Member) stated when she (V22) went to visit R1 at the facility her call light and personal cell phone were out of her reach. V22 stated she moved them where R1 could reach them and after leaving the facility attempted to call R1 on her personal cell phone. V22 stated R1 didn't answer but called back later that evening and told her when she called R1's phone was where she couldn't reach it. 2. R2's Resident Face Sheet with a print date of 4/22/25 documents R2 was admitted to the facility on [DATE] with diagnoses that include chronic obstructive pulmonary disease, diabetes, acute kidney failure, anxiety, reduced mobility, muscle weakness, insomnia, and pain. R2's Minimum Data Set (MDS) dated [DATE] documents R2 has a memory problem and has modified independence in cognitive skills. R2's current Care Plan documents a Problem area with a start date of 7/12/19, Transfer Program- Assist of two utilizing a stand aide. This same Care Plan documents a Problem area with a start date of 7/12/19 of, (R2) is at risk for falls r/t reduced independent mobility, Dx of weakness, dementia .incontinence, non-ambulatory. This Problem Area includes the intervention with a start date of 7/2/19 of, Encourage (R2) to call for assistance with transfers. (continued on next page)

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 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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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 4/21/25 at 9:06 AM, R2 was observed sitting in a wheelchair in her room, facing the foot of her bed. R2's call light was looped on the headboard of the bed, out of R2's reach. On 4/21/25 at 9:16 AM, this surveyor entered R2's room with V1 (Administrator) present. R2 remained in her wheelchair at her bedside. R2's call light remained on the headboard of R2's bed. When asked if R2 could reach her call light, V1 (Administrator) stated, Maybe. R2 did not respond to this surveyors questions regarding her call light. 3. R3's Resident Face Sheet with a print date of 4/22/25 documents R3 was admitted to the facility on [DATE] with diagnoses that include displaced fracture of right femur, Alzheimer's disease, and muscle weakness. R3's MDS dated [DATE] documents a BIMS (Brief Interview for Mental Status) score of 10, which indicates a moderate cognitive deficit. R3's current Care Plan documents a Problem area with a start date of 2/24/25 of, (R3) is at risk for falls r/t reduced independent mobility, DX of Alzheimer's disease, osteoporosis .incontinence .fall prior to admission . This Problem area documents an intervention with a start date of 2/24/25 of, Instruct (R3) to call for assist before getting out of bed or transferring. Encourage her to stand slowly. On 4/21/25 at 9:13 AM, R3 was sitting in a wheelchair in her room with her feet resting on her bed. She was sitting approximately mid way down the bed with the bedside table between her and the nightstand that was sitting at the head of the bed. R3's call light was wrapped around the head board of the bed out of R3's reach. R3 was able to move her legs off the bed but would have had to move the night stand to be able to reach the call light. On 4/21/25 at 9:23 AM, this surveyor entered R3's room with V1 (Administrator) present. R3 remained in the same position with her call light still wrapped around the head board of her bed. V1 (Administrator) stated R3 may be able to reach her call light. 4. R4's Resident Face Sheet with a print date of 4/22/25 documents R4 was admitted to the facility on [DATE] with diagnoses that include diabetes, pain, difficulty walking, and muscle weakness. R4's MDS dated [DATE] documents a BIMS of 12, indicating R4 has a moderate cognitive impairment. R4's current Care Plan documents a Problem area with a start date of 11/11/2020 of, (R4) is at risk for falls r/t reduced independent mobility .She is hard of hearing and has a communication board. (R4) transfers self at times putting her at risk for a fall .This Problem area includes an intervention with a start date of 11/16/21 of, Encourage (R4) to use a call light for supervision with transfers and needed assistance. On 4/21/25 at 9:11 AM, R4 was laying in bed with her call light looped around the head of her bed. R4 does not appear to be able to reach her call light. On 4/21/25 at 9:17 AM, this surveyor entered R4's room with V1 (Administrator) present. R4 remained in bed sleeping with call light still looped around the head of her bed. V1 (Administrator) stated R4 could probably reach her call light. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 4/21/25 at 4:30 PM, R4 was laying in bed with call light hanging down from the wall on the opposite side of the night stand and draped from the opposite side of the night stand to the top with the button laying facing the bed. At 4:34 PM, V8 (CNA/Certified Nursing Assistant in training) entered R4's room. V8 stated maybe R4 threw her call light onto the table. When asked if R4 would be able to reach her headboard, V8 assisted R4's arm above her head and R4's arm did not reach the head board. 5. R5's Resident Face Sheet with a print date of 4/22/25 documents R5 was admitted to the facility on [DATE] with diagnoses that include pain, unsteadiness on feet, muscle weakness, and hypertension. R5's MDS dated [DATE] documents a BIMS score of 06, indicating R5 has a severe cognitive deficit. R5's current Care Plan documents a Problem area with a start date of 8/23/23 of, (R5) is at risk for falls r/t reduced independent mobility . This Problem area includes an intervention of Instruct (R5) to call for assist before getting out of bed or transferring . On 4/21/25 at 9:20 AM, R5 was sitting in a wheelchair with a table between her and the bed. R5's call light was looped around the head of the bed. When asked how she got assistance if she needed it, R5 stated the little red button. R5 started looking for the call light and was not able to locate it. R5 was not able to locate it without this surveyors assistance. R5 attempted to reach her call light and was unable to. V1 (Administrator) was present during this observation and asked R5 if she could go get assistance if she needed it. R5 stated yes she could go find someone if she needed assistance. 6. R8's Resident Face Sheet with a print date of 4/22/25 documents R8 was admitted to the facility on [DATE] with diagnoses that include cerebral infarction, weakness, lack of coordination, anxiety, dementia, and polyneuropathy. R8's MDS dated [DATE] documents a BIMS score of 02, indicating R8 has a severe cognitive deficit. R8's current Care Plan documents a Problem area dated 10/17/22 of, (R8) is at risk for falls r/t reduced independent mobility This Problem area includes the intervention dated 10/17/22 of, Instruct (R8) to call for assist before getting out of bed or transferring . On 4/21/25 at 9:11 AM, R8 was sitting in a wheelchair near her bed. R8's call light appeared to be running from the wall under the blankets on R8's bed. This surveyor was not able to locate the call light. On 4/21/25 at 9:18 AM, this surveyor entered R8's room with V1 (Administrator) present and asked where R8's call light was. V1 pulled R8's call light out from under the blankets on her bed near the head of R8's bed. R8 was sitting in a wheelchair with a table between her and the bed. When asked if R8 would have been able to reach the call light, V1 (Administrator) stated, Maybe. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 4/22/25 at 9:05 AM, V17 (RN/Registered Nurse) stated R2 doesn't use her call light. V17 stated R2 doesn't provide her own care she just prefers to call out for assistance. V17 stated R3 uses her call light. V17 stated R4 is able to use her call light but usually provides her own care with little assistance. V17 stated R5 does everything on her own and doesn't use her call light for anything. When asked if the call light was only to be used to get assistance for care or if it was also there in case of an emergency, V17 stated yes it can be used if there is an emergency. V17 stated R8 could use her call light but likes to stay in bed until staff get her for meals or care. When asked if she would have expected all of the residents call lights to be within their reach, V17 stated, Yes, they should have been. 7. R10's Resident Face Sheet with a print date of 4/22/25 documents R10 was admitted to the facility on [DATE] with diagnoses that include lack of coordination, asthma, diabetes, repeated falls, incontinence, and heart failure. R10's current Care Plan documents a Problem area with a start date of 4/21/25 of, (R10) is at risk for falls r/t reduced independent mobility . This Problem area includes an intervention dated 4/21/25 of, Instruct (R10) to call for assist before getting out of bed or transferring On 4/21/25 at 3:54 PM, R10 was sitting in a wheelchair next to her bed. R10's call light was in the bed under [NAME] the bed pad on the opposite side of the bed. V5 (LPN/Licensed Practical Nurse) got the call light, moved the bedside table that was between R10 and the bed, and pushed R10 closer to the bed so she could reach the call light. R10 stated she could self propel her wheelchair but she was not able to reach the call light where it had been. 8. R11's Resident Face Sheet with a print date of 4/22/25 documents R11 was admitted to the facility on [DATE] with diagnoses that include heart disease, chronic kidney disease, depression, and malignant neoplasm of breast. R11's current Care Plan documents a Problem area dated 4/16/25 of, (R11) is at risk for falls r/t reduced independent mobility . This Problem area includes an intervention dated 4/16/24 of, Instruct (R11) to call for assist before getting out of bed or transferring . On 4/21/25 at 3:59 PM, R11 was sitting in her room in a wheelchair near the window. R11's call light was on the opposite side of the bed. V5 (LPN) got R11's call light and place it near R11. On 4/22/25 at 10:14 AM, V11 (CNA/Certified Nursing Assistant) stated both R10 and R11 are physically able to use their call lights. V11 stated as a CNA she would expect the call lights to be within reach of residents. The facility Call Light policy dated 01/04 documents, Objectives: 1. To respond to resident's request and needs 6. Offer further services before leaving resident's room. Can I do anything for you? Be sure call light is within reach before leaving room.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 32765 Based on interview and record review the facility failed to properly store medications by pre-pouring medications and administering more than one residents medications at a time. This has the potential to affect all 103 residents currently residing at the facility. Findings Include: The facility Daily Census Report dated 4/21/2025 documents 103 residents currently reside at the facility. The untitled letter from V22 (Family Member) to V1 (Administrator) dated 4/13/25 documents in part, Improper Medication Handling and Storage: Medication cups containing loose, pre-poured pills labeled for different patients were repeatedly observed stacked on top of medication carts by multiple nurses (V9/Licensed Practical Nurse, V6 (LPN), and others), most recently on 04/13/2025. This practice violates CMS (Central Management Services) medication safety regulations (F760 and F761), which require that medications be administered to one patient at a time and securely stored until use. Leaving multiple patients' medications exposed and unattended creates a high risk for cross-contamination, medication errors, and misadministration, and reflects a systemic failure in clinical oversight. On 4/21/25 at 12:34 PM, V22 (Family Member) stated she was at the facility visiting R1 and saw V6 (LPN/Licensed Practical Nurse) and another unknown nurse preparing medications for multiple residents at one time by placing the medications in small clear medication cups, labeling the cup with the resident name, and leaving the cups sitting unattended on top of the medication carts. On 4/22/25 at 10:14 AM, V11 (Certified Nursing Assistant) stated she had seen unknown nurse's prepare medications in advance using little medication cups. V11 stated they sometimes set them up in cups, wrote the residents name on them, and then dispensed a couple at a time. On 4/22/25 at 10:35 AM, when asked if he prepared medications in advance of administration, V6 (LPN/Licensed Practical Nurse) stated if he had multiple residents sitting at a table he would prepare all of their medications in medication cups and write their names on them. V6 stated then he would take all of the medication cups to the residents sitting at the table at the same time. On 4/22/25 at 11:50 PM, V2 (Director of Nurses) stated nursing staff are not supposed to pop the medications out of the pharmacy cards prior to administration. V2 stated they should take each resident their medication prior to preparing the next resident's medications. V2 stated they should prepare a resident's medications, administer the medication, sign the medication administration record indicating it was administered, then move to the next resident. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The facility policy Medication Administration using eMAR (electronic medication administration record) dated 11/11 documents, Objective: 1. To provide the resident with those medications deemed necessary by the physician 11. Documentation of meds (medications) given will be done in a consistent manner by the nurse documenting preparation and administration of the medicine on the eMAR .Documentation on the eMAR will be done at the time of administration of the medication. The National Coordinating Council for Medication Error Reporting and Prevention website found at https://www.nccmerp. org/recommendations-health-care-organizations-reduce-medication-errors-associated-related-devices documents under, Recommendations for Healthcare Organizations to Reduce Medication Errors Associated with the Label, Labeling, and Packaging of Pharmaceutical (Drug) Products and Related Devices documents These recommendations apply to healthcare systems, hospital systems, individual hospitals, long-term care facilities, and other organized health care settings. The Council recommends the following: Healthcare organizations should develop processes to ensure that all medications are labeled prior to administration to a patient per USP (United States Pharmacopeial Convention) General Chapter 7 Labeling, the term 'labeling' includes all labels and other written, printed, or graphic matter on a medication ' s immediate container or on, or in, any package or wrapper in which it is enclosed, except any outer shipping container.The term 'label' is that part of the labeling on the immediate container. All clinician-prepared medications or solutions should be labeled, unless the medication or solution is prepared at the patient ' s bedside and is immediately administered to the patient without any break in the process. In accordance with State/Federal Laws and Regulations, healthcare organizations should employ machine-readable systems (e.g., bar coding) in the management of the medication use process. Healthcare organizations should utilize industry standards to ensure machine-readable validity meets industry quality standards. Healthcare organizations should have procedures in place to address gaps and failure modes in the use of machine-readable systems. Healthcare organizations should have policies and procedures developed for repackaging of medications that will clarify labeling and include a bar code to help prevent errors. Systematic approaches, including Healthcare Failure Mode and Effects Analysis (HFMEA) and root cause analysis (RCA), should be implemented within the healthcare organization to identify and evaluate actual and potential causes of errors related to labeling and packaging (e.g., failure to use bar code scanning, barcodes that don ' t scan, and situations where patient armbands cannot be applied). These systematic approaches should be accompanied with guidance related to monitoring, auditing, and quality improvement initiatives (e.g., PDSA-Plan-Do-Study-Act) to ensure changes improve the labeling of medications to reduce medication errors. Healthcare organizations should develop and implement (or provide access to) education and training programs for healthcare professionals, technical support personnel, patients, and families/caregivers that address methods for reducing and preventing medication errors associated with the information provided on an organization ' s medication labeling .