STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175229	A. Building B. Wing	06/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Parkway Operator LLC	749 Blake Street Edwardsville, KS 66111

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 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident?s advance directives. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview, and observation, the facility failed to provide cardiopulmonary resuscitation (CPR-an emergency lifesaving procedure performed when the heart stops beating) for Resident (R) 1 who had a documented desire for full resuscitative measures. On [DATE] at approximately 01:25 PM, Certified Nurse Aide (CNA) M was called to R1's room where R1 was leaned back against the toilet and mumbling. CNA M and CNA N called for Licensed Nurse (LN) G and placed R1 into her wheelchair because she asked to be laid down. During this time, LN G came in, assessed R1, and gave her some lorazepam (an antianxiety medication - a class of medications that calm and relax people) to help calm her down. The three staff then moved R1 towards her bed, and during that time, R1 became unresponsive. R1 was limp and did not respond to verbal or tactile stimuli but staff did not initiate CPR and placed R1 in bed. LN G ignored the green sticker on the door, which indicated the resident's desire for full resuscitative measures, and returned to the nurse's station, where he reviewed the resident's Electronic Medical Record (EMR) and identified the resident's Full Code status, but LN G did not implement CPR. The facility's failure to ensure staff provided CPR for cardiac arrest, per R1's documented wishes, placed R1 in immediate jeopardy.Finding included:- R1's EMR documented diagnoses of encephalopathy (a broad term for any brain disease that alters brain function or structure), altered mental status, chronic systolic heart failure (a condition in which the left ventricle of your heart, which pumps most of the blood, has become weak), diabetes mellitus (DM- when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin) type two, muscle weakness, and vascular dementia (a progressive mental disorder characterized by failing memory and confusion caused by a decreased blood flow to the brain). R1's Significant Change Minimum Data Set (MDS) dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of eight, which indicated moderately impaired cognition. R1's MDS assessment recorded R1 elected hospice services (specialized medical care for persons suffering from life-threatening illness, providing comfort and quality of life measures). R1's Care Plan initiated [DATE] included R1 elected a Full Code Status and CPR measures to be performed. Staff were directed to respect R1's wishes and rights regarding her decision to have CPR performed. R1's plan of care further instructed communication of her choice to all appropriate staff members and to initiate CPR if R1 was found pulseless or breathless and continue CPR until paramedics arrived to take over. R1's Orders tab documented a physician's order dated [DATE] for Full Code, all measures. R1's Orders tab documented a physician's order dated [DATE] for lorazepam intensol oral concentrate two milligrams (mg)/milliliter (ml) administer 0.5 ml by mouth every one hour as needed for anxiety. LN G's Nurses Progress Note dated [DATE] at 02:47 PM documented R1 called out to staff requesting assistance to the bathroom. Staff assisted R1 to the bathroom and noted difficulty with posture while R1 sat on the toilet. When staff attempted to assist R1 back to her wheelchair, R1 repeatedly stated she wanted to lie down. R1, who was normally a one staff assist with transfers, required two staff assistance with a stand and pivot transfer, due to increased weakness. R1 began yelling, Hey, Hey, and became increasingly restless. LN G administered R1's lorazepam as ordered to assist with restlessness. LN G (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 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	documented that during the follow-up assessment to evaluate the effectiveness of the medication, LN G noted R1's posture became limp. R1 was unresponsive to touch and verbal stimuli, no pulse or respirations were observed, and R1's color changed. The facility's report dated [DATE] documented that R1 received hospice services, and LN G incorrectly assumed R1 had a Do Not Resuscitate (DNR) code status. R1's code status was reviewed and identified it should have remained listed as a Full Code. The event was reported due to the failure to verify R1's code status prior to determining interventions for an unresponsive resident. The facility report further documented the root cause analysis identified a failure to verify code status for an unresponsive resident due to an assumption of staff based upon the resident's hospice status. The facility report documented corrective actions were initiated, including immediate re-education with staff regarding mandatory verification of code status for all unresponsive residents, regardless of hospice enrollment status; a facility-wide audit of current resident code statuses was completed and verified for accuracy; a mock code drill was conducted to validate staff competency and understanding of emergency response expectations. LN G's unnotarized Witness Statement dated [DATE] documented CNA staff assisted R1 in the restroom, and one staff member called out to LN G for assistance. LN G observed R1 leaning back on the toilet while staff tried to assist her. LN G documented two staff members assisted R1 into her wheelchair due to her increased weakness. While transferring R1, the resident repeatedly yelled out that she wanted to lie down and then started yelling out, Hey, Hey, Hey, and became more restless. LN G administered R1's prescribed lorazepam for anxiety and agitation to help with her restlessness. LN G then assessed R1 for medication effectiveness during which time R1 became limp, and unresponsive to touch and verbal stimuli. LN G noted R1 had no pulse, respirations, and R1's color had changed and she became pale. CNA N's unnotarized Witness Statement dated [DATE] documented she answered R1's bathroom call light and assisted R1. CNA N noted R1 was mumbling and leaning back. As R1 leaned back, CNA N called for help. CNA N and CNA M then called for LN G due to R1 seeming off. R1 was able to stand for peri care and to transfer to her wheelchair. CNA N documented R1 was repeating, Help me, and I'll lay down. CNA N documented that as staff were about to transfer R1 to bed, R1 started leaning, LN G gave R1 some medicine, R1's eyes rolled back, and then that was it. CNA M's unnotarized Witness Statement dated [DATE] documented she was called to assist with R1. CNA M documented upon arrival to assist with R1, R1 laid back on the toilet mumbling. CNA M asked R1 what was wrong, and R1 continued to mumble. CNA M documented that was when LN G was called to assist with R1's care and assess R1. CNA M documented that CNA N, LN G and herself proceeded to clean up R1 and assist R1 off of the toilet and into her wheelchair. R1 began yelling and stated she wanted to lie down, repeatedly. CNA M further documented when all three staff members went to try and get R1 into bed, they noticed R1 went unresponsive, her eyes rolled back, and she started to slide out of her wheelchair. On [DATE] at 09:08 AM, CNA M stated she was assisting another resident when she was called to the room to assist the CNA in the room with R1. R1 leaned back against the toilet and was mumbling. CNA M asked R1 if she was ok, and R1 just continued to mumble. CNA M and CNA N got R1 into her wheelchair, and she asked to be laid down. She kept repeating that she wanted to lay down. During this time, her nurse came in and assessed her and gave her some medication to help calm R1 down. Afterwards, the staff moved R1 towards her bed because she wanted to lie down. CNA M noted R1 became unresponsive, and staff moved her onto the bed. R1 was limp and not responding to anything. CNA M stated she knew R1 was a Full Code prior to going on to hospice but also knew that after R1 went on to hospice, there was talk about her code status. CNA M said she thought the nurse would know, so she left it to the nurse. CNA M said the color under the name tags on the door revealed the code status of the resident, and that the color codes were there when this occurred with R1. CNA M stated the code status was also listed in the Plan of Care (POC), the Treatment Administration Record (TAR), and staff could check the door. CNA M stated that [NAME] meant the resident was a Full Code, and red meant the resident was a DNR. On [DATE] at 12:47 PM, LN G stated staff alerted him that R1 kept screaming. LN G assisted with getting R1 cleaned up and (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	transferred into her wheelchair. LN G stated he gave R1 her lorazepam to help calm her down, but about two to three minutes later, R1 kept yelling Hey. LN G stated he observed R1 go unresponsive and die right there. LN G stated he made a mistake because he thought R1 was a DNR, and then, when LN G was looking at R1's chart, he noticed that she was a Full Code. LN G stated he knew it sounded bad, but R1 died in that moment, and LN G did not feel that he would have been able to get R1 back. LN G revealed that about ten minutes had passed from when R1 stopped breathing to when LN G knew her actual code status. LN G stated the code status was listed outside of the door; green for Full Code and red for DNR. LN G said when he left R1's room that day he did not think to look at the door to see R1's code status. LN G further stated that if he had looked, he did not think the end results would have been different. LN G stated he would have done CPR and then called 911 to make that final call. On [DATE] at 11:35 PM, Administrative Nurse D stated she expected staff to start CPR if the resident was a Full Code. She further stated that if a resident was a DNR, she expected the staff to assess the resident and notify the appropriate people. Administrative Nurse D stated there was some confusion because the resident was on hospice. Administrative Nurse D stated that ultimately, LN G was terminated because he should have checked the code status, and the green name tag (indicating Full Code) was outside of R1's room. The facility's Cardiopulmonary Resuscitation (CPR) and Basic Life Support (BLS) policy, last approved in March of 2026, directed that staff must maintain current CPR certification for Healthcare Providers through a CPR provider whose training included a hands-on session either in a physical or virtual instructor-led setting in accordance with accepted national standards. The policy further directed that staff were to verify the presence of advanced directives regarding CPR upon admission per policy. On [DATE] at 02:30 PM, Administrative Nurse D and Administrative Nurse E received a copy of the Immediate Jeopardy [IJ] Template and were notified that beginning on [DATE], the facility's failure to perform CPR on R1, placed R1 in IJ. The facility identified, immediately implemented, and completed corrective actions as follows:1. The nurse involved was immediately suspended on [DATE]. LN G was terminated on [DATE].2. The Director of Nursing (DON) or designee completed all staff training on advanced directives and how to identify the code status in the medical record, face sheet, physician orders, or other approved facility documentation, and nursing staff were reminded of the importance of accurate communication during shift report and ensuring code status documentation remained current and easily accessible was completed ([DATE]).3. Facility-wide code status audit was completed ([DATE]).4. A mock drill was completed to verify facility staff responded appropriately to an unresponsive resident ([DATE]).5. The concerns and corrective actions would be reviewed through the facility's Quality Assurance Performance Improvement (QAPI) program. Trends, audit results, and compliance would be monitored, and additional interventions would be implemented as needed to ensure sustained compliance. Due to the correction actions completed prior to the onsite survey, the deficient practice was deemed past non-compliance at a scope and severity of J (isolated with actual harm).