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	08/07/2024

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 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45668 The facility identified a census of 36 residents. The sample included 13 residents with one resident reviewed for hospitalization . Based on observation, interview, and record review, the facility failed to provide written notification of transfer to Resident (R)43 and/or their representative, with a written notice specifying the location and reason for R43's facility-initiated transfer. This deficient practice placed R43 at risk for miscommunication between the facility and resident/representative and possible missed opportunities for healthcare services. Findings included: - R43 admitted to the facility on [DATE] and discharged to hospital on 05/20/24. The Medical Diagnosis section within R43's Electronic Medical Records (EMR) included diagnoses of acute kidney failure, chronic obstructive pulmonary disease (COPD- a progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing), chronic respiratory failure, heart failure, muscle weakness, and type two diabetes mellitus (DM-when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin). R43's Discharge Minimum Data Set (MDS) completed 05/20/24 noted a Brief Interview for Mental Status (BIMS) of 15 indicating intact cognition. R43's EMR indicated a comprehensive MDS assessment was not completed due to his recent admission. No Care Area Assessment (CAA) was completed at the time of his discharge. R43's EMR under Progress Note indicated he experienced right lower quarter abdominal pain during a therapy session and was sent out to an acute medical facility for treatment. The EMR lacked documentation showing written notification of transfer was provided to R43 or his representative. On 08/07/24 at 08:45 AM Social Service, Staff X stated a written notification of transfer was not issued to R43 or his representative because the facility believed he was coming back. She stated the facility would usually just call the family to inform them of the transfer rather than provide written notification. (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
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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 08/07/24 at 09:20 AM Administrative Nurse D stated the facility called family members for transfer notification and did not provide a written form or documentation. The facility did not provide a policy related to written notification and bed hold for discharges and transfers as requested on 08/07/24. The facility failed to provide a written notification of transfer for R43. This deficient practice placed R43 at risk for miscommunication between the facility and resident/representative and possible missed opportunities for healthcare services.

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45668 The facility identified a census of 36 residents. The sample included 13 residents with one resident reviewed for hospitalization . Based on observation, interview, and record review, the facility failed to provide a copy of the facility bed hold policy to Resident (R)43 and/or their representative, with a written notice specifying the duration and cost of the bed hold policy, at the time of the resident's transfer to the hospital. This deficient practice had the risk of impaired ability to return to the facility and to the previous room for R43. Findings included: - R43 admitted to the facility on [DATE] and discharged to hospital on 05/20/24. The Medical Diagnosis section within R43's Electronic Medical Records (EMR) included diagnoses of acute kidney failure, chronic obstructive pulmonary disease (COPD- a progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing), chronic respiratory failure, heart failure, muscle weakness, and type two diabetes mellitus (DM-when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin). R43's Discharge Minimum Data Set (MDS) completed 05/20/24 noted a Brief Interview for Mental Status (BIMS) of 15 indicating intact cognition. R43's EMR indicated a comprehensive MDS assessment was not completed due to his recent admission. No Care Area Assessment (CAA) was completed at the time of his discharge. R43's EMR under Progress Note indicated he experienced right lower quarter abdominal pain during a therapy session and was sent out to an acute medical facility for treatment. R43's EMR lacked documentation showing a bed hold was provided to R43 or his representative. On 08/07/24 at 08:45 AM Social Service Staff X stated a written notification of transfer or bed hold was not issued to R43 or his representative because the facility believed he was coming back. She stated the facility would hold the bed for residents transferring out to the hospital. On 08/07/24 at 09:20 AM Administrative Nurse D stated the facility called family members for hospital transfers. She stated the facility believed R43 was returning and didn't need to provide the form. The facility did not provide a policy related to written notification and bed hold for discharges and transfers as requested on 08/07/24. The facility failed to provide a bed hold policy notice to R43 or his representative when he transferred to the hospital. This deficient practice had the risk of impaired ability to return to the facility and to the previous room for R43.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41713 The facility identified a census of 36 residents. The sample included 13 residents. Based on observation, record review, and interview, the facility failed to ensure Resident (R) 37's comprehensive care plan addressed his functional abilities and how much assistance was needed from staff. The facility failed to ensure R37's comprehensive care plan included a care area and interventions for Foley catheter (a tube inserted into the bladder to drain urine into a collection bag) care. This placed R37 at risk of impaired care due to uncommunicated care needs. Findings included: - R37's Electronic Medical Record (EMR) documented diagnoses of respiratory failure, urinary tract infection (UTI-an infection in any part of the urinary system), and chronic obstructive pulmonary disease (COPD- a progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing). R37's Admission Minimum Data Set (MDS) dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of 12 which indicated moderately impaired cognition. R37 required partial to moderate assistance with tub and shower transfers and substantial to maximal assistance with his functional abilities. R37 had an indwelling catheter. R37's Functional Abilities Care Area Assessment (CAA) dated 06/29/24 documented R37 was a new admission and required assistance with activities of daily living (ADLs) and had a BIMS of 12. R37 was at risk for self-care deficits. R37's Urinary Catheter CAA dated 06/29/24 documented R37 required assistance with toileting hygiene and had an indwelling catheter. R37 was at risk for UTI. R37's Care Plan revised on 07/17/24 directed staff he had a tracheostomy (opening through the neck into the trachea through which an indwelling tube may be inserted) and staff was to ensure the ties were secured at all times. Staff was directed to reassure the resident to decrease his anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear). R37's Care Plan revised on 06/26/24 lacked a care area and interventions to direct staff on the amount of assistance R37 required with his ADLs. R37's Care Plan revised on 06/26/24 lacked a care area and interventions to address R37's Foley catheter. On 08/06/24 at 08:40 AM R37 laid on his back in his bed. R37's head of the bed was elevated at about 45 degrees, his enteral feeding (provision of nutrients through the gastrointestinal tract when the resident cannot ingest, chew, or swallow food) was infusing, and the tracheostomy tube was intact and secured. R37's catheter was below the bladder level and secured to the bed rail in a dignity bag. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 08/07/24 at 01:26 PM, Licensed Nurse (LN) G stated that care plans were a group effort, but she completed the comprehensive care plans. LN G stated R37 had gone to the hospital shortly after his admission so his care plan had not been completely updated. LN G stated R37's Care Plan had been overlooked and she had not realized that his care plan lacked staff direction for his ADLs and catheter care. On 08/07/24 at 01:37 PM Administrative Nurse D stated R37 had gone out to the hospital before the completion of his comprehensive assessment and had not noticed that his care plan had not been updated with interventions for his ADLs and catheter. The Comprehensive Care Plans policy last revised in August 2022 documented: The comprehensive care plan was based on a thorough assessment that included, but was not limited to, the MDS and physician's orders. Assessments of residents were ongoing and care plans were revised as information about the resident and resident's condition changed. The care plan should describe the resident's nursing, medical, physical, mental, and psychosocial preferences. The care plan should include person-specific, measurable objectives and time frames with a goal to measure progress towards meeting such. The facility failed to ensure R37's comprehensive care plan addressed his functional abilities and how much assistance was needed from staff for ADL care and his Foley catheter. This placed R37 at risk of impaired care due to uncommunicated care needs.

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F 0657 Level of Harm - Minimal harm or potential for 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45668 The facility identified a census of 36 residents. The sample included 13 residents with 13 reviewed for care plan revisions. Based on observation, record review, and interviews, the facility failed to revise Resident (R)6's Care Plan to reflect his bowel incontinence needs. The facility additionally failed to revise R22's plan to include preventative offloading of his heels and ankles. This deficient practice placed both residents at risk for complications related to uncommunicated care needs. Findings Included: - The Medical Diagnosis section within R6's Electronic Medical Records (EMR) included diagnoses of congestive heart failure (CHF-a condition with low heart output and the body becomes congested with fluid)), type two diabetes mellitus (DM-when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin), muscle weakness, benign prostatic hyperplasia (BPH-non-cancerous enlargement of the prostate which can lead to interference with urine flow, urinary frequency and urinary tract infections), and spinal stenosis (degenerative condition of the spine that could cause weakness and loss of use of extremities). A review of R6's Quarterly Minimum Data Set (MDS) completed 05/09/24 noted a Brief Interview for Mental Status (BIMS) score of nine indicating moderate cognitive impairment. The MDs indicated he had functional impairments to both lower extremities and used a wheelchair. The MDS indicated he was dependent on staff for bathing, toileting, and transfer. The MDS indicated he had frequent incontinence of bowel and bladder. The MDS indicated he was not on a toileting program. R6's Urinary Incontinence Care Area Assessment (CAA) completed 09/14/23 indicated he was frequently incontinent and required assistance with toileting. The CAA noted he was at risk for skin breakdown and urinary tract infections related to his incontinence. The CAA noted a care plan was developed to provide goals and to minimize the risks associated with incontinence. R6's Functional Abilities CAA completed 09/14/23 indicated he required assistance with his activities of daily living (ADLs) related to his physical and cognitive impairments. The CAA noted a care plan was developed to provide goals and to minimize the risks associated with an ADL decline. R6's Care Plan initiated 08/30/22 indicated he was at risk for functional limitations and an ADL deficit related to his medical diagnoses. The plan noted he required extensive assistance from one staff for bathing, bed mobility, dressing, transfers, and toileting. The plan noted R6 had stress incontinence of his bladder and instructed staff to encourage fluids to promote voiding and monitor for signs of infections. The plan lacked documentation related to his assessed bowel incontinence and his need for disposable incontinence products. R6's EMR revealed a Nursing: Bowel Incontinence evaluation completed on 05/09/24. The evaluation indicated he had impaired cognitive function and mobility. The evaluation noted he had bowel incontinence, and his care plan would be updated. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R6's EMR revealed a Nursing: Bladder Incontinence evaluation completed 02/21/23. The evaluation indicated he had urgency bladder incontinence. The evaluation indicated he was required to wear adult incontinence briefs at all times. On 08/05/24 at 10:55 AM R6 sat on his bed in his room. A portable urinal was placed next to his bedside table. R6 reported he needed assistance with toileting and wore incontinent briefs. On 08/06/24 at 10:32 AM Certified Nurse Aide (CNA) M stated the care plan should include detailed interventions related to R6's incontinence needs. She stated he required an incontinence brief to be worn at all times. She stated staff were required to provide frequent checks for incontinent residents. On 08/07/24 at 10:15 AM Licensed Nurse (LN) G stated the care plan should include the daily care needs for each resident. She stated the plans were updated quarterly by the interdisciplinary team. She stated all staff had access to view the care plan information. On 08/07/24 at 01:31 PM Administrative Nurse D stated the care plans should include what products and services are required for daily ADLs. She stated the bowel and bladder assessment results should be used to provide interventions to the residents. She stated the evaluations should be used for the care plans. The facility's Care plan policy revised 08/2022 stated each resident will have a comprehensive assessment and provided individualized interventions to reflect their treatment needs. The policy indicated the care plans will be reviewed and updated to reflect changes that may occur with the resident's goals and care needs. The facility failed to revise R6's Care Plan to reflect his bowel incontinence needs. This deficient practice placed R6 at risk for incontinence complications and uncommunicated care needs. 47834 - The Diagnoses tab of R22's Electronic Medical Record (EMR) revealed diagnoses for muscle weakness, a need for assistance with personal care, lack of coordination, abnormal posture, transient cerebral ischemic attack (TIA- temporary episode of inadequate blood supply to the brain), and venous insufficiency (poor circulation). The Annual Minimum Data Set (MDS) dated [DATE], documented R22 had a Brief Interview for Mental Status (BIMS) score of 15 which indicated intact cognition. The MDS documented R22 had functional limitation in range of motion (ROM) to both upper and lower extremities with impairment to both sides. The MDS documented R22 was dependent on staff for bathing, toileting, and mobility. The MDS documented R22 had no unhealed pressure ulcers at stage one (pressure wound which appears reddened, does not blanche, and may be painful but is not open) or higher. The Quarterly MDS dated [DATE], documented R22 had a BIMS score of 14 which indicated intact cognition. The MDS documented R22 was dependent on staff for his Activities of Daily Living (ADL) and mobility. The MDS further documented R22 was at risk for pressure ulcers and had one or more unhealed pressure ulcers at stage one or higher. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Pressure Ulcer/Injury Care Area Assessment (CAA) dated 12/22/23, documented R22 was dependent on two or more staff for bed mobility and was at risk for pressure ulcers or other skin integrity issues. The CAA further documented R22 had a low air loss mattress (a mattress used to help prevent skin breakdown by distributing the patient's body weight over a broad surface area). R22'sCare Plan with an initiated date of 01/20/22, documented R22 was at risk for skin breakdown due to impaired mobility and a history of skin breakdown with the right knee documented under the focus section. R22's Care Plan with an initiated date of 10/21/21, documented R22 had chronic pain due to physical disability, emotional distress, a history of hip fracture, back pain, and contractures (abnormal permanent fixation of a joint or muscle). R22's Care Plan lacked evidence of any pressure-reducing measures for R22's bilateral lower extremities to prevent pressure ulcers. A Nursing: Weekly Skin Condition Report dated 06/18/24, documented R22 had a pressure wound to his right knee with a first observed date of 06/16/24. A Nursing Weekly Skin Evaluation dated 07/25/24 documented R22 had redness and non-skin tear open areas to the right knee and right inner ankle. On 08/06/24 at 11:44 AM an observation revealed R22 rested in his room in bed. R22 lay on his back, with the head of the bed elevated. R22's torso leaned to the left side and his hips were rotated to the left with his knees bent. His right leg rested on top of his left leg. He was covered in a blanket and had a pillow between his thighs. On 08/07/24 at 07:56 AM R22 rested in bed. R2's torso leaned to the left, his hips were rotated to the left and his right leg rested on top of his left leg with his knees bent. R22 had one pillow between his thighs and one between his lower extremities. On 08/07/24 at 11:43 AM Consultant HH stated R22 was receiving therapy services weekly for ROM. Consultant HH stated therapy was working with R22 to help improve his positioning. Consultant HH stated they had begun using a brace on R22 to help straighten his legs as R22's contractures (abnormal fixation of a muscle or joint) limited his movement; however, he further stated due to R22's knee wound they had to stop using the braces until his wound healed. Consultant HH stated they attempted to use a wedge to help offload some of the pressure on R22's knees and ankle; however, R22 was resistive to their interventions at times. Consultant HH stated R22 was agreeable to using a pillow between his thighs and lower legs to reduce pressure. On 08/07/24 at 12:17 AM Consultant GG stated their department had worked with R22 to help improve his positioning and ROM for two years now. Consultant GG stated they had attempted offloading measures, such as wedges or pillows before R22's wounds formed; however, R22 would decline placement of the devices at times, and they would have to reintroduce them or try new interventions as R22 would allow. Consultant GG stated after R22's knee wound was discovered, they attempted to reintroduce pressure-reducing measures for his bilateral extremities, and R22 was agreeable to using pillows between his legs. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 08/07/24 at 01:26 PM, Licensed Nurse (LN) G stated the plans were updated quarterly by the interdisciplinary team. She stated all staff had access to view the care plan information. LN G stated R22's Care Plan should have had information related to his refusals of care and interventions. LN G further stated staff had tried many things for R22's pressure-related issues in a short amount of time and wasn't sure if all the interventions had been entered into his care plan; however, LN G stated pressure-reducing measures should have been on R22's Care Plan. On 08/07/24 at 01:31 PM Administrative Nurse D stated R22's Care Plan should have the information required for staff to provide care for him. Administrative Nurse D stated the pressure-reducing measures used by staff for R22, along with his refusals, should have been updated on his care plan. The facility's Care plan policy revised 08/2022 stated each resident will have a comprehensive assessment and provided individualized interventions to reflect their treatment needs. The policy indicated the care plans will be reviewed and updated to reflect changes that may occur with the resident's goals and care needs. The facility failed to revise the care plan with an intervention for pressure-reducing measures for R22's bilateral lower extremities to prevent the development of further pressure ulcers. This deficient practice placed R22 at risk for increased risk for pressure ulcer development due to uncommunicated care needs.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. 45668 The facility reported a census of 36 residents. The sample included 13 residents with two reviewed for pressure ulcers (localized injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear and/or friction). Based on observations, interviews, and record review, the facility failed to ensure Resident (R)17's low air-loss mattress pump was appropriately set to his recommended weight range. This deficient practice placed R17 at risk for complications related to skin breakdown and pressure ulcers. Findings Included: - The Medical Diagnosis section within R17's Electronic Medical Records (EMR) included diagnoses of type two diabetes mellitus (DM-when the body cannot use glucose, not enough insulin is made or the body cannot respond to the insulin), cerebral infarction (stroke - sudden death of brain cells due to lack of oxygen caused by impaired blood flow to the brain by blockage or rupture of an artery to the brain), neuromuscular bladder dysfunction (dysfunction of the urinary bladder caused by a lesion of the nervous system), dysphagia (difficulty swallowing), muscle weakness, and paralytic ileus (function paralysis of the nerve around the digestive tract). R17's Quarterly Minimum Data Set (MDS) completed 05/04/24 noted a Brief Interview for Mental Status (BIMS) score of zero indicating severe cognitive impairment. The MDS indicated he was dependent on staff assistance for bed mobility, toileting, transfers, bathing, and dressing. The MDS indicated he had impairments to both sides of his upper and lower extremities. The MDS indicated he was at risk for pressure ulcers. The MDS indicated he had no active pressure injuries. The MDS noted he had pressure-reducing devices for his bed and wheelchair, a repositioning program, and non-surgical dressings in place. The MDS indicated he received enteral nutrition (provision of nutrients through the gastrointestinal tract when the resident cannot ingest, chew, or swallow food). The MDS indicated he weighed 155 pounds (lbs.). R17's Pressure Ulcer Care Area Assessment (CAA) completed 02/04/24 revealed he was at risk related to his incontinence and need for assistance with bed mobility. The CAA indicated he needed a special mattress or seat cushion to reduce or relieve pressure. R17's Care Plan initiated 04/12/19 indicated he was at risk for skin breakdown and pressure ulcers related to his medical diagnoses and limited mobility. The plan indicated he was dependent on staff assistance for bed mobility, transfers, toileting, personal hygiene, dressing, and bathing. The plan instructed staff to reposition and monitor for skin breakdown. The plan instructed staff to provide preventative skin treatment and peri-care. The plan lacked indication related to the low air-loss mattress weight setting and monitoring requirements. R17's EMR under Physician's Order revealed an order for a pressure reduction (low air-loss) mattress. The order indicated his bed weight was 430 pounds (lbs.) (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the low air-loss mattress's manufacturer operation manual (New Source Medical's Air Force One Model) indicated the alternating air mattress system was designed for patients who were at risk or had pressure ulcers. The manual indicated the bed's weight capacity weight was from 80 to 1000lbs. The manual indicated the mattress's internal pressure should be adjusted according to the patient's weight. The manual indicated the bed's weight setting could be adjusted for comfort one increment at a time until comfort is achieved. On 08/05/24 at 08:15 AM R17 slept in his bed. His bed was in the medium position. The head of his bed was elevated above 30 degrees. R17 had a low air-loss mattress system (Air Force 1000 model). The mattress control panel's weight was set to 300 lbs. On 08/07/24 at 10:12 AM R17 slept in his bed. His low air-loss mattress was set to 180 lbs. On 08/07/24 at 10:15 AM Licensed Nurse (LN) G stated the low air-loss mattress bed was set based on the weight of the residents. She stated some of the residents had preset weight orders recommended by the manufacturer and should have been set based on the order. She stated staff were expected to check the low air-loss mattresses each shift for functionality and safety. On 08/07/24 at 01:43 PM Administrative Nurse D stated an outside company came in to install the low air-loss mattresses and set the weight settings. She stated staff don't not adjust the weight setting of the bed. She stated the mattress weight setting should be set by weight but was not sure why R17's air mattress was recommended for 430 lbs. The facility's Prevention of Pressure Injuries policy revised 08/2022 indicated the facility will assess and identify residents at risk for developing pressure-related injuries. The policy indicated the facility will implement interventions to prevent injuries as well as promote healing for existing injuries. The policies noted the facility will utilize preventative skin treatments, techniques, and pressure-reducing equipment to ensure appropriate healing and prevention. The policy indicated the facility will implement pressure redistributing devices, wedges, and repositioning. The facility failed to ensure R17's low air-loss mattress pump was appropriately set to his weight range. This deficient practice placed R17 at risk for complications related to skin breakdown and pressure ulcers.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. 41713 The facility identified a census of 36 residents. The sample included 13 residents. Based on observation, record review, and interview, the facility failed to ensure the medication error rate did not exceed five percent (%) when staff crushed and mixed Resident (R) 37's medications without a physician's order to administer via a gastrostomy tube (G-tube: tube surgically placed through an artificial opening into the stomach). This resulted in a medication error rate of 23.08%. Findings included: - On 08/06/24 at 09:43 Licensed Nurse (LN) H prepared R37's medications for administration via G-tube. LN H had R37's Medication Administration Record (MAR) pulled up on her laptop for R37. LN H crushed six medications including citalopram hydrobromide (a medication used to treat depression), prednisone (a steroid medication used to decrease inflammation), a probiotic (a supplement used for digestive disorders), vitamin D3, senna (medications used to treat constipation), and sotalol (a beta-blocker sued to treat hypertension) and emptied the crushed medications into a medication cup and added water. LN H went to R37's bathroom and returned with two 60-milliliter (ml) syringes filled with the medications. LN H stopped R37's enteral nutrition (provision of nutrients through the gastrointestinal tract when the resident cannot ingest, chew, or swallow food) that infused via a Kangaroo pump (an enteral feeding pump used to deliver continuous or intermittent feeding). LN H disconnected the enteral tubing port from R37's G-tube hub and placed the tubing end on a barrier towel. LN H then opened an alcohol wipe and cleaned the G-tube hub and the tip of each 60 ml syringe with the medications in them. LN H connected one of the 60 ml syringes to the G-tube hub and administered the medications into the G-tube. LN H repeated with the second syringe with medication. LN H disconnected the syringe from R37's G-tube, wiped the end of the enteral feeding tubing with an alcohol wipe, reconnected the tubing to the G-tube, and restarted the enteral feeding. LN H did not flush the G-tube before the administration of the medications as well as after administration. A review of R37's physician's orders revealed that R37 lacked a physician's order to crush and mix medications for administration. R37's MAR documented an order dated 05/24/24 to crush medications as appropriate. On 08/07/24 at 10:36 AM LN G stated that it was the policy of the company that enteral medications could be mixed when administered unless contraindicated. LN G stated that R37's MAR should have the order to mix the medications when being administered via G-tube as well as the amount of water to flush the G-tube with before and after the medication administration. On 08/07/24 at 01:37 PM Administrative Nurse D stated that each resident who received medications via G-tube should have a physician's order to indicate that medications could be administered mixed as well as the amount of water to flush the tube with before and after mediation administration. The facility failed to provide a policy for Medication Administration or Medication Errors. (continued on next page)

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	08/07/2024

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

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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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility failed to ensure the medication error rate did not exceed five percent when staff failed to ensure R37 had a physician's order to administer medications mixed via a G-tube. This resulted in a medication error rate of 23.08%.

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F 0851 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data. 47834 The facility had a census of 36 residents. Based on observation, interview, and record review, the facility failed to submit complete and accurate staffing information through Payroll Based Journaling (PBJ) as required. This deficient practice placed the residents at risk for unidentified and ongoing inadequate nurse staffing. Findings included: - The PBJ report provided by the Centers for Medicare & Medicaid Services (CMS) for Fiscal Year (FY) 2023 Quarter 3, FY 2024 Quarter 1, and FY 2024 Quarter 2 indicated the facility did not have licensed nurse coverage 24 hours a day, seven days a week on multiple (20) dates. A review of the facility licensed nurse timeclock data for the dates listed on the PBJ revealed a licensed nurse was on duty for 24 hours a day seven days a week. On 08/07/24 at 01:26 PM, an observation revealed a licensed nurse on duty in the facility. On 08/07/24 at 01:10 PM Administrative Staff B stated they verify hours through their clock-in system and then upload the hours to the PBJ, and corporate then sends the final report. Administrative Staff B stated they had to enter agency staffing hours manually based on the invoice information. Administrative Staff B stated if there were any discrepancies then it would likely be due to agency staffing hours as they were manually entered. The facility did not provide a policy related to PBJ reporting upon request. The facility failed to submit complete and accurate staffing information through PBJ as required. This deficient practice placed the residents at risk for unidentified and ongoing inadequate nurse staffing.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 45668 The facility identified a census of 36 residents. The facility identified nine residents on Enhanced Barrier Precautions (EBP-infection control interventions designed to reduce transmission of resistant organisms that employ targeted gown and glove use during high contact care). Based on record reviews, observations, and interviews, the facility failed to implement signage or indicators within the physical environment to alert staff and visitors of the required EBP. These deficient practices placed the residents at risk for infectious diseases. Findings Included: -An initial walkthrough of the facility was completed on 08/05/24 at 07:10 AM. An inspection of Resident (R)35's room revealed an over-the-door storage bin for personal protective equipment (PPE). The bin contained gloves, gowns, masks, and foot covers. An inspection of R35's room revealed no signage or indicator of precautions she was on. R35 had a tracheostomy (opening through the neck into the trachea through which an indwelling tube may be inserted) and a percutaneous endoscope gastrostomy tube (PEG-a tube inserted through the wall of the abdomen directly into the stomach). An inspection of R17's room revealed an over-the-door storage bin for PPE but lacked signage or precaution indicators. R17 had a tracheostomy, PEG-tube, and Foley catheter (a tube inserted into the bladder to drain urine into a collection bag). An inspection of R2's room revealed an over-the-door storage bin for PPE but lacked signage or precaution indicators. R2 had a PEG-tube. An inspection of R12's room revealed an over-the-door storage bin for PPE but lacked signage or precaution indicators. R12 had a Foley catheter. An inspection of R22's room revealed an over-the-door storage bin for PPE but lacked signage or precaution indicators. R22 had a Foley catheter. An inspection of R24's room revealed an over-the-door storage bin for PPE but lacked signage or precaution indicators. R24 had a Foley catheter. An inspection of R37's room revealed an over-the-door storage bin for PPE but lacked signage or precaution indicators. R37 had a tracheostomy, PEG-tube, and Foley catheter. An inspection of R27's room revealed an over-the-door storage bin for PPE but lacked signage or precaution indicators. R27 had a fistula (abnormal passage from an internal organ to the body surface or between two internal organs) for her dialysis (a procedure where impurities or wastes were removed from the blood). An inspection of R18's room revealed an over-the-door storage bin for PPE but lacked signage or precaution indicators. R18 had a fistula for his dialysis treatment. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 08/07/24 at 10:15 AM Licensed Nurse (LN) G stated the EBP rooms did not contain signage or indicators related to what precautions were needed. She stated the nursing team passed down which residents were on EBP and what PPE was required. She stated the electronic medical records (EMR) indicated if a resident was on EBP. She stated agency, visitors, and outside vendors could ask the nurse what PPE was required upon arrival. On 08/07/24 at 01:31 PM Administrative Nurse D stated the EMR had a stop sign logo on the resident's online chart to signify they were on EBP precautions. She stated no signage or indicators were posted in or outside the rooms. She stated visitors would need to ask staff before entering the rooms. She stated the proper PPE was supplied outside the rooms and signage would be posted if the resident was on contact precautions. The facility's Enhanced Barrier Precautions (EBP) policy revised 03/2024 indicated the facility will identify and assess individuals at risk for infections related to open wounds or bacterial colonization. The policy stated the facility would provide the appropriate PPE including gowns and gloves to use during high-contact care. The policy noted the facility will utilize High Contact Care signage for residents on EBP. The facility failed to implement signage or indicators within the physical environment to alert staff and visitors of the required EBP. These deficient practices placed the residents at risk for infectious diseases.