

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175229	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/29/2026
NAME OF PROVIDER OR SUPPLIER Parkway Operator LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 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.			
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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation and interview, the facility failed to maintain a sanitary kitchen to prepare food for the residents who received meals from the kitchen. Findings included:- On 07/28/2026 at 11:52 AM, during observation of the kitchen, three Hydrion PH sanitizer paper testing strips, stored above the three-compartment sink, were found outdated, with two that had expiration dates of 09/30/2018 and one with an expiration date of 07/15/2025. On 07/27/2026 at 11:52 AM, Dietary Staff BB stated he was unaware the testing strips had an expiration date. Upon request, the facility failed to provide a policy on kitchen sanitation.		

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 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. Based on interview and record review, the facility failed to follow the latest guidelines from the Centers for Disease Control and Prevention (CDC) to administer the COVID-19 vaccine following written consent or obtain informed declination documentation for Resident (R) 2, R1, R8, and R23. Findings included: 1. R2's Electronic Medical Record (EMR) documented a declination for the COVID-19 booster vaccine on 06/14/2024, but lacked a current declination for the latest COVID-19 booster. 2. R1's EMR documented a COVID booster received on 06/14/2023. The facility had a consent for a COVID-19 booster vaccine to be administered but lacked a signature date or record that R1 had received the most current vaccine. 3. R8 EMR documented a consent for a COVID-19 booster dated 07/20/2026 but lacked documentation that R8 had been administered the current COVID-19 booster vaccine. 4. R23 documented the declination of a COVID-19 booster on 12/18/2024. The facility failed to document a current COVID-19 booster vaccine offer. On 07/29/2026 at 11:29 AM, Administrative Nurse D verified the lack of documentation related to the COVID-19 vaccine. Administrative Nurse D reported the facility utilizes the month of October to update the immunization status for the residents. The facility works with the local health department for the administration of vaccines. Administrative Nurse D verified the residents should receive information and the most current vaccination recommendations from the CDC. The facility's Vaccination of Residents, including influenza, Pneumococcal, RSV and COVID-19 dated 09/2025 documented the community will offer the COVID-19 vaccination when available to the community. The vaccine may be offered and provided directly by the community or through a third-party arrangement with a pharmacy partner, local health department, or other appropriate health entity. The residents or their representatives will receive education on the benefits and risks of receiving the COVID-19 vaccine. Document refusals in the medical record.		

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to complete a recapitulation (a concise summary of the resident's stay and course of treatment in the facility) for Resident (R) 48, upon the resident's discharge from the facility. Findings included: - R48's Electronic Medical Record (EMR) documented diagnoses of dementia without behavioral disturbances (a progressive mental disorder characterized by failing memory and confusion), heart failure, and diabetes mellitus (DM- when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin) type two. The admission Minimum Data Set (MDS), dated [DATE], documented R48 had moderately impaired cognition. R48 required supervision with toileting hygiene, showers, transfers, and set-up assistance with personal hygiene. R48 had lower functional impairment on both sides, did not ambulate, and wanted to be discharged back to the community. R48's 05/20/2026 Care Plan documented the following interventions for R48: 05/21/2026- Talk to his family member to make sure she was on board with him living with her. The care plan directed staff to work with the KCVA (Kansas City Veterans Administration) to obtain assistance with transferring R48 to the Veterans Administration (VA) in Illinois and to address the financial issues associated with moving out of state. The care plan further directed staff to educate R48 on good self-care behavior, and Social Services (SS) would provide visits to assist R48 with the adjustment and to help with discharge planning. The Nurse's Note, dated 06/02/2026 at 08:53 AM, documented R48 went to Social Services X and stated he was discharging home with his family today. R48 stated his family member was in Kansas City and planned to pick him up. The note further documented that nursing staff were notified and would get their discharge paperwork ready. The Nurse's Note, dated 06/02/2026 at 10:01 AM, documented R48 was discharged from the facility to home and picked up by family; the Nurse Practitioner (NP) was notified and ordered to have R48 discharged from the facility. R48's EMR lacked a recapitulation of his stay in the facility. On 07/28/2026 at 11:09 AM, Administrative Nurse D verified there was no recapitulation for R48's stay. Administrative Nurse D stated that normally the discharge paperwork was started at admission, but R48 was originally supposed to be long-term; one day he came and stated his ride was coming and he was going home. The facility's Discharge Summary and Plan policy, dated 03/2026, documented that when a resident's discharge was anticipated, a discharge summary and post-discharge plan would be developed to assist the resident to adjust to his/her new living environment, that was safe and able to provide the care they required post-transfer. The discharge summary would include a recapitulation of the resident's stay at the facility, and a final summary of the resident's status at the time of the discharge and as permitted by the resident.		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. Based on observation, interview, and record review, the facility failed to adequately store drugs and biologicals for Resident (R) 35, R15, and R38 when staff failed to date insulin upon opening. Findings included:- On 07/27/2026 at 08:40 AM, during the initial tour of the facility, Licensed Nurse (LN) H was preparing medications. Upon inspection of the medication cart, R35's Novolog (short-acting insulin) pen, R15's Glargine (long-acting insulin) pen, and the R38 Novolog vial lacked an open date. LN H verified the facility's policy was to date insulin when opened for use, and insulin should have been dated with the open date. On 07/29/2026 at 11:54 AM, Administrative Nurse D verified that the insulin should be dated when opened and put into use. The facility's Storage of Medications policy, dated 10/2024, documented that the facility shall not use discontinued, outdated, or deteriorated drugs or biologicals. All such drugs shall be returned to the dispensing pharmacy or destroyed, per state regulation.		

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to ensure coordinated care and services provided by the facility with the care and services provided by hospice for one resident, Resident (R) 4. Findings included:- R4's Electronic Medical Record (EMR) documented diagnoses 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), diabetes mellitus (DM-when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin), tracheostomy (opening through the neck into the trachea which an indwelling tube may be inserted), and dysphagia (swallowing difficulty). R4's Quarterly Minimum Data Set (MDS), dated [DATE], documented that R4's cognition was not assessed. R4 was dependent upon staff for all activities of daily living (ADL). The MDS documented the resident received tracheostomy care, had a gastrostomy tube (G-tube: a tube surgically placed through an artificial opening into the stomach, and received hospice services. R4's 06/02/2026 Care Plan documented the following interventions for R4: 09/09/2025- The care plan directed staff to administer medication as ordered, monitor for verbal and nonverbal cues of pain, and intervene accordingly. The care plan directed staff to notify Hospice of any changes in condition and had a DNR (do not resuscitate). The care plan lacked the frequency and type of support visits, supplies, and medical equipment provided by hospice. Review of R4's clinical record revealed the resident was admitted to hospice care on 09/06/2025. The facility had a plan of care provided by hospice in a communication book dated 06/04/2026. On 08/27/2026 at 08:30 AM, R4 was in bed with his eyes closed. On 07/29/2026 at 1:18 AM, Administrative Nurse F stated she was new to the position and had training on the care plan process. Administrative Nurse F further stated she would update the care plan with the information required related to his Hospice care. On 07/29/2026 at 12:10 PM, Administrative Nurse D stated the care plan should reflect the care provided by both the staff and Hospice. The facility's Hospice Program policy, dated 12/2025, documented the community may contract for hospice services for residents who wish to participate in such programs, including services that would be provided and the coordination of services. To promote continuity of care, collaborate with the hospice, nursing home, and resident/representative on a coordinated care plan noted in the medical record to include, but not limited to, resident choices regarding care, all services needed, interventions based on assessments, and the provider responsible for performing specific services.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, interview, and record review, the facility failed to implement Enhanced Barrier Precautions (EBP- infection control interventions designed to reduce transmission of resistant organisms, which employ targeted gown and glove use during high-contact care) for Resident (R) 5 and R35's wound care and R4's gastrostomy tube (G-tube: tube surgically placed through an artificial opening into the stomach) and tracheostomy care (opening through the neck into the trachea through which an indwelling tube may be inserted). Findings included:- On 07/29/2026 at 10:33 AM, Licensed Nurse (LN) I provided wound care for R5's buttock pressure ulcer (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). LN I donned gloves, removed the soiled dressing, then proceeded to clean the wound and apply ordered treatment and dressing to the wound. LN I failed to utilize a gown barrier, which was available at the resident's door, during any part of the procedure. On 07/29/2026 at 11:00 AM, LB I provided wound care for R35's ulcer to the plantar (bottom) area of the right foot. LN I donned gloves to remove the dressing. LN I then donned a barrier gown to complete the treatment and dressing. LN I stated that she had forgotten to place a barrier gown on to provide wound care, due to being nervous during the observation of the care for wounds on both R5 and R35. On 07/29/2026 at 11:33 AM, Administrative Nurse D verified that staff should have donned a gown and gloves during the treatment of wounds. The facility's Multidrug-Resistant Organisms (MDRO) and Enhanced Barrier Precautions (EBP) policy, dated 05/2026, documented that EBP expanded the use of PPE and referred to the use of gowns and gloves during high-contact resident care activities that provide opportunities for transfer of MDRO's to staff hands and clothing. MDROs may be indirectly transferred from resident-to-resident during these high-contact activities. Nursing Home residents with wounds and indwelling medical devices are at especially high risk of both acquisition of and colonization with MDROs. - On 07/28/2026 at 08:15 AM, R4's room door had an Enhanced Barrier Precautions (EBP -infection control interventions designed to reduce transmission of resistant organisms, which employ targeted gown and glove use during high contact care) sign and a door caddy with gowns and gloves in it. Licensed Nurse (LN) G went into R4's room to administer morning medications via R4's gastrostomy tube (G-tube: a tube surgically placed through an artificial opening in the stomach) and to perform tracheostomy (opening through the neck into the trachea, through which an indwelling tube may be inserted) care. LN G washed his hands and donned clean gloves and used a 60-milliliter (mL) syringe to check for residual (the amount of fluid remaining in the stomach before a feeding or at regular intervals) before administering his medications. LN G removed his soiled gloves, washed his hands, and donned a new pair of gloves. LN G flushed his G-tube with 60 mL of water, administered the medications, and flushed his G-tube with another 60 mL of water. Further observation revealed LN G removed his soiled gloves, washed his hands, donned clean gloves, and prepared R4 for tracheostomy care. LN G removed the 4 x 4 gauze pad (medical dressings used to clean, cover, and absorb drainage from wounds) from under the tracheostomy tube. LN G changed his gloves and stated his right hand was his sterile hand, and then he cleansed the area with a mixture of sterile saline and hydrogen (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	peroxide. LN G removed the inner cannula (a removable tube that slides inside the main tracheostomy tube) and put in a new one. LN G changed his gloves, removed the tracheostomy tie (a securement strap that holds a tracheostomy tube firmly in place against the neck), and replaced it with a clean one. LN G then took R4's oxygen saturation (percentage of oxygen in the blood). On 07/28/2026 at 08:40 AM, LN G stated both the residents in the room were on EBP precautions and staff were supposed to wear a gown and gloves while providing care to R4. On 07/29/2026 at 12:18 PM, Administrative Nurse D stated staff are to wear a gown and gloves with cares for any resident on EBP. The facility's Multidrug-Resistant Organisms (MDRO) and Enhanced Barrier Precautions (EBP) policy, dated 05/2026, documented enhanced barrier precautions are used during high -contact resident care activities. For residents with indwelling medical devices such as feeding tubes and tracheostomies, staff are to wear personal protective equipment (PPE- gowns, face shields and/or eyeglasses/goggles, and gloves).		

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F 0851 Level of Harm - Potential for minimal harm Residents Affected - Many Note: The nursing home is disputing this citation.	Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data. Based on observation, interview, and record review, the facility failed to submit complete and accurate staffing information through the Payroll-Based Journal (PBJ- an electronic record mandated by the Centers for Medicare and Medicaid Services (CMS) that details direct care staffing hours worked in long-term care settings) as required, resulting in a trigger for excessively low weekend staffing. Findings included:- The PBJ report provided by the Centers for Medicare & Medicaid Services (CMS) for Fiscal Year (FY) 2026 Quarter (Q) 1 and Q2 indicated excessively low weekend staffing. Review of the facility's Nursing staffing schedules for the above quarters revealed adequate staffing on duty was provided. On 07/29/2026 at 12:15 PM, Administrative Nurse D stated Administrator A submitted the nursing information for the PBJ report and stated they were always staffed well on the weekends, as they do have agency staff assisting when needed. The facility's Payroll Based Journal policy, dated 10/2025, documented the community would submit payroll data in a uniform format to CMS, including staffing information for community, agency, and contract staff. The facility distinguished employees from agency and contract staff and reported information about direct care staff, and they specified whether the individual is an employee of the facility or is engaged by the facility under contract or through an agency.		