

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175229		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 09/02/2026	
NAME OF PROVIDER OR SUPPLIER PARKWAY OPERATOR LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 749 BLAKE STREET , EDWARDSVILLE, Kansas, 66111			
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F0000	INITIAL COMMENTS			F0000			
F0760 SS = D	The following citations represent the findings of complaint investigation 3172512. The census was 37. The sample included three residents. Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- \$483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is NOT MET as evidenced by: Based on record review and interviews, the facility failed to ensure Resident (R) 1 remained free from significant medication errors when staff failed to verify the correct dose was drawn up prior to administering liquid morphine (an opioid pain reliever used to manage moderate -to-severe acute and chronic pain) to R1. Findings included: - R1's Electronic Medical Record (EMR) documented diagnoses of acute and chronic respiratory failure with hypoxia (inadequate supply of oxygen), seizures, hemiplegia and hemiparesis (weakness and paralysis on one side of the body) following a 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), dysphagia (swallowing difficulty), and encephalopathy (a broad term for any brain disease that alters brain function or structure). R1's "Five-Day Minimum Data Set (MDS)" dated 08/13/2026 documented R1 was in a persistent vegetative state. R1 was dependent on staff for assistance with all activities of daily living. R1's MDS documented he took anti-anxiety (a class of medications that calm and relax people) and opioid (a class of controlled drugs used to treat pain)			F0760	"Past Noncompliance - no plan of correction required"		

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 reverse for further 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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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F0760 SS = D	Continued from page 1 medications during the seven-day look-back period. R1's "Orders" tab documented the following physician orders for morphine: Morphine solution 10 milligrams (mg)/5 milliliters (mL), take 1 mL (2 mg) per tube every one hour as needed for pain or discomfort, ordered 08/13/2026 and discontinued on 08/15/2026. Review of R1's "August Medication Administration Record (MAR) 2026" documented R1 received morphine (at the incorrect dose) on the following dates: 08/14/2026 at 08:00 PM, pain scale of 4 out of 10 with an Ineffective (I) follow-up after administration. 08/14/2026 at 09:36 PM, pain scale of 5 out of 10 with an I follow-up after administration 08/14/2026 at 11:01 PM, pain scale of 6 out of 10 with an I follow-up after administration. 08/15/2026 at 01:43 AM, pain scale of 5 out of 10 with an I follow-up after administration. 08/15/2026 at 03:19 AM, pain scale of 5 out of 10 with an I follow-up after administration. 08/15/2026 at 04:51 AM, pain scale of 6 out of 10 with an Unknown (U) follow-up after administration. Review of the R1's "Controlled Substance Proof of Use" log documented the following administration with the amount administered: Date Time Quantity used Quantity remaining Nurse Signature 08/14/2026 08:00 PM 5 mL 175 mL Licensed Nurse (LN) G 08/14/2026 09:36 PM 5 mL 170 mL LN G 08/14/2026 11:01 PM 5 mL 165 mL LN G 08/15/2026 01:43 AM 5 mL 160 mL LN G 08/15/2026 03:19 AM 5 mL 155 mL LN G 08/15/2026 04:51 AM 5 mL 150 mL LN G	F0760					

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F0760 SS = D	Continued from page 2 The "Nursing Note" dated 08/15/2026 at 06:36 AM documented facility staff notified R1's hospice provider, family, and facility on-call manager of a morphine medication error with a stable baseline. The "Nursing Note" dated 08/15/2026 at 08:07 AM, Late Entry, documented R1 was administered the incorrect doses of morphine sulfate solution. R1 was ordered to receive 1 mL of Morphine every hour but accidentally received 5 mL every hour for five different times throughout the shift. The "Nursing Note" dated 08/15/2026 at 12:29 PM documented R1's family requested he be sent out to an emergency room. R1's vital signs were obtained that morning: blood pressure 104/64, Temperature 97.5 degrees Fahrenheit, pulse 62 beats per minute, and respirations 11 breaths per minute; oxygen saturation of 94% on room air. R1 breathed evenly, unlabored, and showed no signs of distress. R1's hospice provider came and evaluated R1 and ordered that all narcotics be held until the next re-evaluation of R1 by another hospice provider. The "Nursing Note" dated 08/15/2026 at 12:51 PM documented that Consultant GG stated there was no need to send R1 out to the hospital due to R1's current condition. Consultant GG directed facility staff to continue to monitor R1. R1's hospice provider contacted R1's family and educated R1's family regarding R1's current condition and encouraged R1's family not to send R1 out to the emergency room. R1's family requested that R1 be taken to the emergency room. R1 was sent to the emergency room. Review of R1's "Hospital Documentation" dated 08/15/2026 documented his trip to the emergency room was to further evaluate R1. The plan upon arrival to the emergency room was to observe and make sure there was no acute deterioration of R1's vital signs. It was determined not to give R1 Narcan (medication used to medically reverse opioid overdoses by rapidly restoring normal breathing and consciousness), due to the likelihood of causing him undue suffering and pain. R1 was monitored in the emergency room for three hours. R1 continued to be somnolent (sleepy, drowsy) but rested very comfortably. R1 was determined to be hemodynamically stable without signs of			F0760			

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F0760 SS = D	Continued from page 3 hypotension (low blood pressure) or progressive tachycardia (rapid heartbeat greater than 100 beats per minute). R1 was discharged back to his hospice provider's care for further monitoring and treatment. The "Nursing Note" dated 08/15/2026 at 05:17 PM documented R1 returned to the facility with no new orders. On 09/02/2026 at 12:53 PM, LN G stated that she did not read the syringe right. LN G stated that for some unknown reason she assumed that the syringe was a 1 mL syringe, but it was bigger than what was usually used. LN G revealed that she noticed the medication error when it was time to count the narcotics in the medication cart and found that the medication was off by 30 mL's and then she realized what had happened. LN G stated that there had been no change in R1's condition through her shift. On 09/02/2026 at 10:54 AM, Administrative Nurse E stated the syringe that was in the bag to be used was hard to read, and it was not until the end of LN G's shift that it was discovered that the count was off and that LN G had actually been using the wrong dose on the syringe that was hard to read. The syringe was thrown away, and one that was able to be easily read was obtained. Administrative Nurse E revealed that once the error was discovered, everyone was notified. Administrative Nurse E stated it was only because the count was off, not a change in the resident, that the medication error was discovered. She stated that it was R1's family who chose to send the resident out to the ER. On 09/02/2026 at 10:55 AM, Administrative Nurse D stated that the nurses have all been educated and training started after the event occurred. She stated that now the staff have to have a second set of eyes on any liquid medication that is being drawn up to prevent this from happening again. The facility's "Controlled Substances" policy, effective 10/2025, documented that liquid controlled substances would be dispensed in opaque bottles indicating an approximate volume. The policy documented that while it may not be absolutely accurate in tracking, there must be a tracking system that includes the amount initially received (starting volume), subtraction of the dose given, and	F0760					

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F0760 SS = D	Continued from page 4 a record of the remaining amount. The facility identified and implemented immediate corrective actions, which were completed by 08/28/2026, including: LN G's teachable moment regarding a medication error and failure to follow the seven rights of medication administration (08/15/2026). Education was provided to all of the licensed nurses regarding medication errors and failure to follow the seven rights of medication administration. The facility implemented a two-staff verification for applicable liquid narcotic medications. Due to the corrective action completed before the onsite survey, the deficient practice was deemed past noncompliance at a "D" scope and severity.		F0760				