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| S 000 | Initial Comments<br><br>Complaint 1853536/IL103049 | S 000 | | |
| S9999 | Final Observations<br><br>Statement of Licensure Violations:<br><br>300.1210b)<br>300.1210d)6)<br>300.3240a)<br><br>Section 300.1210 General Requirements for Nursing and Personal Care<br><br>b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. Restorative measures shall include, at a minimum, the following procedures:<br><br>d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis:<br><br>6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents. | S9999 | **Attachment A**<br>**Statement of Licensure Violations** | |

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| S9999 | Continued From page 1<br>Section 300.3240 Abuse and Neglect<br><br>a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act)<br><br>These Regulations were not met as evidenced by:<br><br>Based on observation, interview and record review the facility failed to recognize and evaluate the risk factors associated with a method of transportation for a follow-up appointment for 2 residents (R1, R3) evaluated for physician follow-up appointments. This failure resulted in R3, a resident experiencing anxiety, crying episodes, increased pain, being terrified, being fearful, having sleeplessness and the inability to progress with therapy.<br><br>The findings include:<br><br>1. According to R3's Electronic Health Record (EHR) R3 is 76 years old, admitted to the facility on May 22, 2018 from a local hospital's Cardiac Care Unit, after receiving a Transcather Aortic Valve Replacement, Balloon Aortic Valvuloplasty, Temporary Pacemaker Placement, Possible Percutaneous Coronary and Peripheral Intervention Transesophagel Echocardiogram (Bilateral). R3's diagnosis include Encounter for other specified surgical aftercare, unspecified dementia without behavioral disturbance, type 2 diabetes mellitus without complications, chronic diastolic (congestive) heart failure, Fibromyalgia, Essential (primary) hypertension Cellulitis of right lower limb, Difficulty in Walking, not elsewhere classified, Weakness, Thrombocytopenia, Other Hyperlipidemia, Atherosclerotic Heart Disease of Native Coronary Artery without Angina Pectoris, | S9999 | | |

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Nonrheumatic Aortic (valve) Stenosis, Pain, Presence of Cardiac Pacemaker-Temporary, Other Specified Depressive Episodes, and Other Specified Arthritis.

According to R3's MDS (Minimum Data Set) assessment dated June 5, 2018 R3 has a BIMS (Brief Interview for Mental Status) score of 15 indicating R3 is cognitively intact, and needs extensive assistance with one person physical assistance with the following activities of daily living: locomotion off unit, and transfers. According to this same MDS, R3 needs extensive assistance with two persons physical assist with toilet use and is at risk for getting a pressure ulcer.

R3's Medication Administration Record dated May 29, 2018 and verified by V20, documents prior to leaving the facility on May 29, 2018, R3 received the following medications: glipizide tablet extended release 24 hour 10 mg; Keflex 500 mg one capsule; levothyroxine 100 mcg; memantine 10 mcg; and metformin 1,000 mg.

R3's physician's order dated May 22, 2018 states "Accu Checks BID (twice a day) and PRN (as necessary). R3's Insulin Administration History report dated May 22, 2018 through May 26, 2018 documents R3's blood sugars were checked three times a day before breakfast, after lunch, and at bedtime. This report further documents R3's blood sugar results were greater than 200 (5) times, greater than 300 (10) times, indicating R3's blood sugar being unstable.

R3's Physical Therapy evaluation dated May 23, 2018 which documents a run date through June 6, 2018 states the reason for referral as "recent hospitalization due to chronic diastolic heart

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failure and aortic valve replacement. Pt (patient) reports a significant decline in functional mobility and strength over the past few weeks. Pt now presents with impairment in gait, balance, safety and LE (lower extremity) strength that limit independence level."

R3's Occupational Therapy evaluation dated May 23, 2018 which document with a run date through June 6, 2018 states the reason for referral as presenting "following a transcatheter aortic valve replacement balloon aortiv valvuloplasty and temporary pacemaker placement and spending approximately 1 week in ICU (intensive care unit). Pt (patient) continues to c/o (complain of) weakness, decreased strength and balance and some confusion requiring increased assistance with all care."

On June 1, 2018 at 3:40 PM during a tearful interview R3 stated a nurse came into her room on May 29, 2018 at around 7:00 AM to tell her she needed to be ready to leave for an appointment. R3 then stated "I told her I didn't have transportation and she said we have a bus coming." R3 further said I got ready and left the facility on a bus thinking I was going to my appointment. R3 stated when she got on the bus at the facility she was the only person on the bus. R3 then stated the bus driver drove me to (nearby town) and turned into "a mall back door J.C. Penny parking lot. I said what are you doing, you can't leave me here and the bus driver replied, Oh yes I can another bus will be here in 40 to 45 minutes." R3 then said she waited 30 minutes, and checked her watch and it was around 8:00 AM and R3 stated "No one was around, no stores open, no cell phone, no nothing!" R3 continued and said she went to the appointment and the receptionist at the doctors office asked me what I

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was doing as the two doctors were not in the office that day. R3 told them she had no one to pick her up. R3 then stated "I was to the point all I could do was cry." R3 said the receptionist said she would call the facility and let them know, she did not have another doctors appointment and this same receptionist told her on three different occasions it would be about 15 minutes before someone would be here to pick her up. R3 stated someone at the doctors office asked her (R3) if there was a family member they could call and R3 had them call her son. R3 verified she left the facility at around 7:30 in the morning and got back to the facility around 1:30 PM that afternoon by ambulance. R3 stated "I was terrified and so upset by the time I got back...I couldn't do therapy for 2 days. I have Fibromyalgia and I went to therapy and tried but I couldn't do it." R3 said the same girl that came in that morning and told her about the appointment told her she could get an extra pain pill if she needed and R3 told her yes she needed one. R3 stated "I cried all night long from fear, I was petrified and hurting. It was a nightmare, I could hardly stand from the Fibromyalgia, I was done for." R3 was crying and and trembling during the conversation and further stated "I felt everyone was staring at me when I got back and they were saying in a low voice "There she is, and that happened to her." R3 then stated after about the third day I started getting good enough to participate in the therapy again." When questioned about a nurse (V6) coming in and discussing the doctors appointments with her and being provided with information about being dropped off and picked up R3 stated "I did not know anything about a doctors appointment until 7:00 AM the morning of the appointment." During this interview R3 was crying, wiping tears with her hands, wringing her hands, and running her hands through her hair intermittently.

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R3's Physical Therapy daily treatment notes for May 27, 2018 through June 2, 2018 indicates a decline in predication of physical therapy on May 29, 2018 and May 30, 2018 with the following statements for May 29, 2018 as "Treatment withheld patient ill" and May 30, 2018 as "...Patient still very emotional/crying over bus ride with (community transportation provider) yesterday. She c/o feeling weak, dizzy, with slight nausea."

R3's Occupational Therapy (OT) participation notes specifies R3's participation in OT decreased on May 29, 2018 with the following note "Res (resident) unavailable after a very long and detrimentally challenge day with doctor appointment, elevated stress and sugar level, withheld due to sickness." On May 30, 2018 Occupational therapy participation was decreased and a note stating "pt (patient) very emotional on this date still regarding yesterday episode. Pt (patient) c/o dizziness and fatigue."

Speech Therapy daily treatment note dated May 29, 2018 states "Validation tech and distraction tech utilized to decrease anxiety from recent doctors office trip where she rode public transportation...Continued validation of feelings which decreased tearfulness and calmed patient."

On June 5, 2018 at 10:00 AM, R3 stated "I'm getting better, I woke up night before last and couldn't go back to sleep for thinking about the whole ordeal, but I'm getting better."

On June 6, 2018 12:00 PM, R3 stated "I'm doing better, I still think about it and everyone here has told me they are sorry it happened."

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| S9999 | Continued From page 6<br><br>A document entitled "After Visit Summary" from a local hospital, page 4 of 9, dated May 22, 2018 lists a follow up appointment with (V17, physician) at the "Valve Clinic" at 9:00 AM on May 29, 2018 and another follow up appointment with (V18, Cardiothoracic Surgery physician) on May 29, 2018 at 10:40 AM both located in the same building.<br><br>Progress notes as follows for R3: 5/22/2018 at 1:21 PM states "76 year old female admitted... accompanied by Family member (V16)." Another progress note dated 5/22/18 at 1:57 PM notes two follow up appointments with V17 and V18 in the same office at a nearby town one at 9:00 AM and the other at 10:40 AM. The note further documents, "Family aware and provided a copy of scheduled appointments."<br><br>R3's Progress note dated May 25, 2018 at 4:11 PM states "Spoke with res (resident) regarding f/u (follow-up) appointment on 05/29/18 at the (a local physician office) in (local nearby town). Res has requested (local community transportation provider) to transport. Called et (and) spoke with... at (local community transportation provider); res will be picked up from facility at 7:35 AM et (and) taken to (major department store) in (local town); res will change buses at 8:35 AM then be taken to appointment. After 2nd (second) appointment is concluded; res will be picked up from (physician office) at 12:15 PM and taken to (major department store) bus stop and change buses at 12:45 PM; res will then be transported back to facility et should arrive back at approximately 1:30 PM...Resident notified et verbalized understanding." This note was signed by V6, Licensed Practical Nurse (LPN).<br><br>According to www.google.com/maps the | S9999 | | |

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physician's office where R3 had the follow-up appointment on May 29, 2018 was 13 miles from the facility and takes 17 minutes to get to the drop off point if there are no other stops.

R3's Progress note for May 29, 2018 at 7:47 AM states "Res (R3) OOF (out of facility) at this time via (local community transportation provider) to f/u appointment with V17 and V18." Another note dated May 29, 2018 at 10:38 AM states V18 called the facility and "notified this nurse res did not have appointment with V18 today. res cardio f/u is scheduled with V19, physician on 6/4/13 (18) @ (at) 3:00 PM. V6, Licensed Practical Nurse (LPN) notified (local community transportation provider) to p/u (pick up) res from V18's office."

R3's Progress note for May 29, 2018 at 11:12 AM, states "(local community transportation provider) unable to p/u res and transport back to facility, V2, Director of Nursing (DON) instructed this nurse to notify (local ambulance service) to p/u res..."

R3's Progress note for May 29, 2018 at 1:30 PM, states "Res returned to facility at this time via (local ambulance service). Res A/O x 3 (alert and oriented to person place and time), res upset, crying and tired, son here in facility to see res, res stated she has never been through such an ordeal. Res stated she was never seen by MD. This nurse notified V17's office r/t appointment.. Son requested copy of discharge order w/ (with) scheduled apts (appointments) and (local community transportation provider) phone number."

R3's Progress note for May 29, 2018 at 3:12 PM "Called and spoke with (V4) she stated res was

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seen at V17's office for a nurse only visit and included a symptom site check and EKG (electrocardiography)."

On June 6, 2018 at 8:41 AM, V16, R3's family member states he received a document with the follow up appointments on it when R3 was admitted into the facility, however he did not know she was going to be dropped off at a mall parking lot to wait on a bus and states "She (R3) was very upset" and further states "She was picked up at the facility at 7:30 AM and I can't imagine a bus driver driving off and leaving her there alone."

On June 6, 2018 at 10:59 AM, V20, Licensed Practical Nurse (LPN) states when R3 returned to the facility she was upset and crying. V20 stated she completed an assessment on R3, all her vital signs were within normal range for her, assisted her to bed, gave her a pain pill, ordered her a meal tray and held her hand. V20 stated she told R3 she was extremely sorry and the supervisors were aware of the situation and they were checking into it. V20 then stated an hour later she (R3) wasn't crying and seemed calmer.

On June 1, 2018 at 4:30 PM, V7, family of R3 said R3 went without necessities for 6 hours from the time she left the facility at 7:30 AM to 1:30 PM, and further said V4 , the Practice Manager called him and said (R3) did not get lunch. V7 stated R3 is Diabetic and takes insulin and eating on a schedule is important. V7 stated that during a phone call with R3 after her return to the facility R3 told him,"she was so emotional she was beside herself." V7 stated,"I feel it was neglectful that she was left outside in the elements to fend for herself." V7 also stated "R3 was out of her normal routine, not knowing if or when she would be picked up and by who, plus having dementia

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and only being in that facility for 7 days after a surgical procedure on her heart." V7 further stated "I believe it was extremely traumatic for her." V7 said what he got from R3's communication that evening was that there was no one around in that parking lot familiar to her, she was sitting in a wheelchair without a cell phone and nothing familiar, that would be upsetting to anyone.

On June 1, 2018 at 2:45 PM, V3, Registrar at physician office says R3's appointment was at 9:00 AM with a nurse and that took about 45 minutes to an hour. V3 stated R3 told her she had another appointment with another physician in the same building but was told that doctor was not in that day. V3 then stated she told the receptionist at the other physician's office to call the facility and tell them R3 needed to be picked up. V3 stated she left for lunch and returned around noon and R3 was still sitting in the waiting room. V3 then stated she called the facility and talked with someone "I believe it was the Director of Nursing (DON) and told them R3 needed to be picked up. I called a second time and was told the DON was working on it." V3 stated she helped R3 to the bathroom a couple of times while she was waiting and stated "I sat with her, gave her something to drink, snacks when she told me she was diabetic she was visibly upset and trembling."

On June 1, 2018 at 1:50 PM, V5, family member of R3 said she met with the (V2, Director of Nursing) today and was told R3's bus was suppose to be a bus to bus transfer and that R3 was not suppose to be alone in that parking lot. V5 stated V2 admitted R3 was crying and upset and the nurses were trying to comfort her. V5 said even her room mate said she (R3) cried and cried when she returned to the facility.

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On June 5, 2018 at 12:34 PM, V6 (LPN), verified R3 was provided with the information regarding the follow-up appointments for May 29, 2018 on May 25, 2018 and documented it in the progress note section of R3's EHR. V6 stated staff of the transportation provider said R3 was supposed to get off one bus and get on another. V6 did not specify if the bus driver was to wait the 30 to 45 minutes for the other bus to get there. V6 then stated "I don't blame her for being upset. I did not tell her she would be dropped off and have to wait in a parking lot for another bus."

On 6/5/18 at 1:30 PM, V13 (local transportation bus driver) stated she typically drove that bus and she made trips to nearby town with that bus route. V13 stated she did not transport to different locations in the nearby town, that she only dropped people off at five central locations and the nearby town bus would pick them up at those locations and take them where they needed to go in the nearby town. When asked if there was a wait between her dropping them off and the nearby town bus picking them up V13 stated, "Yes, 15-30 minutes."

On 6/5/18 at 3:54 PM, V14 (local transportation bus driver) stated he did at times drive the bus to the nearby town and would drop the individuals from the facility off at the bus stop. When asked if the nearby town bus was waiting for them when he would drop the residents off V14 stated, "Not always. Sometimes they have to wait for the next bus, but if they want special transportation so they don't have to wait for the bus they just have to call our office and schedule it."

On June 6, 2018 at 10:23 AM, V2, Director of Nursing (DON) said V20, LPN told her the

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doctors office had called concerned because R3 was telling them she had sat in a parking lot for 45 minutes waiting on a bus. V2 stated she called V21, Director of Operations at the community transportation facility and left a message. V2 stated between 10:00 AM and 10:38 AM an employee from the physician office called and said they were done with R3 and and could not get a-hold of the community transportation company to pick her up. V2 then stated she told the employee, R3 had another appointment with another physician at their same building V2 stated that later on V20 told her that R3 did not have a second appointment with V18 and the physician's office staff could not get in touch with the community transportation system to pick R3 up. V2 further said V20 was instructed to call the community transportation provider and was told it would be a while. V2 then told V20 to call the local ambulance company to pick R3 up at the doctors office and bring her back. V2 said when V21 (Director or Operations with the local community transportation provider) was informed what had happened with R3 being dropped off in the parking lot to wait on a bus to pick her up V21 stated to V2, "Oh I'm so appalled, that is not suppose to ever happen with your residents." V2 then stated that V21 would start an investigation and get back with us with the results. When questioned about the progress note by V6 stating R3 was being picked up at 7:35 AM and changing buses at 8:35 AM and the parking lot where R3 was to change buses was 13 miles away from the facility on June 6, 2018 at 3:30 PM, V2 stated "they make other stops along the way, we did not know they were going to leave her in the parking lot."

On June 5, 2018 at 2:30 PM, V1 (Administrator) stated she had a verbal agreement with the local

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| | IL6014385 | A. BUILDING: _____ B. WING _____ | C 06/06/2018 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| PARKWAY MANOR | 3116 WILLIAMSON COUNTY PARKWAY MARION, IL 62959 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
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transportation service to pick up the resident's at the facility and complete a bus to bus transfer or they would take them directly to the door of their appointment. V1 stated that leaving a resident waiting for another bus was not suppose to happen. V1 said she had called V21 and was told she would find out what happened with R3 and was told it was a driver error and that V21 knew that resident's at that facility were to be taken directly to there destination and not dropped off somewhere waiting for another bus to pick them up. V1 then stated "I told her I could not trust that service anymore and that I would authorize an ambulance transport if necessary before I would use them to go out of town anymore."

A letter dated June 6, 2018 from the community transportation provider states "In our assessment of what occurred the customer (R3) was scheduled on the wrong route. To compound the situation the driver broke protocol and didn't call the office. The driver gave the customer the option to stay on the bus or be dropped off at the (major department store) stop under the canopy. This is not normal operating procedure for (formal name of facility) customers. We have a para transit bus without transfers that she should be scheduled on."

2) R1's care plan "snapshot" dated 5/25/18 documents R1 is a 79 year old male whose diagnoses include; left total knee arthroplasty (replacement), pain, type 2 diabetes mellitus without complications, hypertension, peripheral vascular disease, unsteadiness on feet, neuropathy, arthritis, osteoarthritis of the knee, spinal stenosis, and cervical disc disorder. R3's care plan also documents R1 requires extensive assistance of two staff to transfer and is at risk for falls.

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| S9999 | Continued From page 13<br><br>On 6/1/18 at 10:30 AM, R1, who is alert and oriented to person, place and time stated he had knee replacement surgery and was at the facility for rehabilitation. R1 stated he had not had any appointments outside of the facility since arriving but he did have one scheduled for Tuesday 6/5/18.<br><br>On 6/1/18 at 11:10 AM, V9 (Certified Nursing Assistant-CNA) stated staff did not accompany residents to appointments. V9 stated if a resident was not able to go by themselves family went with them or the physician came to the facility.<br><br>On 6/6/18 at 10:09 AM V2 (Director of Nursing) stated the facility assists residents with scheduling transportation based on the residents choice. Residents can be transported by a local transportation company, a cab, or family. If a resident goes by a local transportation company or a cab the nursing staff gather pertinent medical information for the resident to take with them. They inform the resident of the appointment and what time they need to be ready for the appointment. The nurse lets the CNA- certified nursing assistant know the resident has an appointment. Staff give the resident their medical records and either takes the resident to the front entrance or the 600 hall entrance or the resident propels themselves to the appropriate entrance to wait for transportation. Upon return to the facility the transportation company will drop them off inside the front entrance or the 600 hall entrance.<br><br>On 6/5/18 beginning at 1:15 PM, R1 was in the 600 hall dining room. R1 stated he was not sure what time his bus would pick him up or where he was supposed to get on the bus. R1 stated he was concerned he was going to miss his | S9999 | | |

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appointment and it was very difficult to get an appointment with his physician. R1 went to the nurses station located between the 300 and 400 hall at 1:20 PM and spoke with the nurse (not identified) she stated she would have to call to find out where he was supposed to be. After the nurse made a phone call, R1 left the nurses station and went towards the 600 hall. A CNA (V11) followed R1 down the 400 hallway and asked him if she could take his wheelchair to the wheelchair clinic. R1 told V11 she could not take his wheelchair since he had an appointment. V11 followed R1 to the exit door located next to the therapy department and obtained R1's pulse prior to putting the code in for R1 to exit. R1 exited the building to wait for the bus, V11 stayed inside the building. A local transportation bus pulled to the curb and lowered the ramp. R1 began to cross the ramp to get onto the bus. The bus driver (V13) stated to R1 she was there to pick up someone else and his bus would be here shortly. R1 was then picked up by a wheelchair accessible bus.

On 6/5/18 at 4:51 PM, V11 (Certified Nursing Assistant) stated she was R1's CNA today (6/5/18) from 5:30 AM until 2:00 PM. V11 stated she was not aware R1 had a medical appointment until he told her in the hallway at approximately 1:30 PM. When asked if it was typical for her to not be aware of a residents appointment V11 stated the nurses usually tell her or they have wrote it down somewhere. When asked how she would know when a resident returned from an appointment V11 stated if they are dropped off up front the staff will call and let their CNA know they are back. If the resident is returned to the back entrance (by the therapy department) the bus driver brings the residents to their hall.

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| S9999 | Continued From page 15<br><br>On 6/5/18 at 3:54 PM the local transportation company bus returned to the facility. The bus driver assisted R1 off the bus using the wheelchair lift. The bus driver (V14) asked R1 if he needed assistance into the building. R1 told V14 he did not need assistance. There were no staff present outside at this time. R1 attempted to push the button that would open the doors into the building. This button did not open the doors. R1 was unable to hold the door open and self propel his wheelchair into the building unassisted.<br><br>On 6/5/18 at 4:41 PM, V12 (CNA) stated he was assigned to R1 after 2 PM on 6/5/18. When asked if he had seen R1, V12 stated, "No, not yet. He is at a doctor's appointment. His family took him and they will sign him back in when he gets back." When asked how he would know when to expect him back V12 stated, "I haven't got word yet."<br><br>(C) | S9999 | | |