STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6014385	A. BUILDING: _____ B. WING _____	04/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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
S 000	Initial Comments Annual Licensure and Certification	S 000		
S9999	Final Observations Statement of Licensure Violations: 1 of 2 300.610a) 300.690b) 300.690c) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.690 Incidents and Accidents b) The facility shall notify the Department of any serious incident or accident. For purposes of this Section, "serious" means any incident or accident that causes physical harm or injury to a resident. c) The facility shall, by fax or phone, notify the Regional Office within 24 hours after each reportable incident or accident. If a reportable incident or accident results in the death of a resident, the facility shall, after contacting local law enforcement pursuant to Section 300.695,	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6014385	A. BUILDING: _____ B. WING _____	04/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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
S9999	Continued From page 1	S9999		

notify the Regional Office by phone only. For the purposes of this Section, "notify the Regional Office by phone only" means talk with a Department representative who confirms over the phone that the requirement to notify the Regional Office by phone has been met. If the facility is unable to contact the Regional Office, it shall notify the Department's toll-free complaint registry hotline. The facility shall send a narrative summary of each reportable accident or incident to the Department within seven days after the occurrence.

These regulations were not met as evidenced by:

Based on interview and record review the facility failed to notify the department of a serious accident resulting in a fracture for 1 (R39) of 4 residents reviewed for accidents in a sample of 40.

The findings include:

R39's Resident Face Sheet documented an admission date of 6/11/24 with diagnoses including: unsteadiness on feet, muscle weakness, and lack of coordination.

R39's 3/18/25 Minimum Data Set (MDS) documented a Brief Interview for Mental Status (BIMS) score of 10, indicating moderate cognitive impairment.

On 4/2/25 at 9:24 AM, R39 said she had a fall in the facility. R39 said after staff helped her to the recliner R39 turned on her call light. R39 said she was wanting to get up to go to the bathroom, but her walker was across the room. R39 said she got up and ambulated to her walker and when she grabbed the walker it slipped and she fell on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6014385	A. BUILDING: _____ B. WING _____	04/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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
S9999	Continued From page 2	S9999		

the walker and broke her arm.

R39's 10/27/24 Resident Progress Notes documented in part " ... This nurse was in hallway when I heard someone cry out. After moving toward the sound I began to hear 'help me, help me.' (R39) observed prone on floor with head in direction of door in front of recliner chair. Asked (R39) what happened, (R39) stated 'I fell, my arm hurts so bad.' Obvious angular deformity to left arm above wrist 3 inches with small amount of blood over deformity .... No noticeable or apparent injury anywhere other than to left forearm ... transported to (hospital) ..."

On 4/4/25 at 11:23 AM, V9 (Licensed Practical Nurse/ LPN) said when he walked into R39's room after she fell, he noted R39's wrist was deformed. V9 said R39's wrist was not deformed prior to the fall.

On 4/4/25 at 12:09 PM, V9 said R39's October 2024 fall was unwitnessed. V9 said he was about 3 rooms away from R39's room when he heard R39 fall and scream.

R39's 10/26/24 hospital record documented in part " ... ED (Emergency Department) Notes ... Patient presents to the ER (Emergency Room) with complaints of left wrist pain and head injury after fall. Patient was walking with walker and tripped and fell landing on her left wrist left side of head. She is complaining of left wrist pain .... Fracture and Fracture- Dislocation ... Wrist injury location: L (Left) wrist ... Wrist fracture type comment: Radial ulnar head transverse fracture with complete displacement ..."

R39's 10/28/24 Progress Note documented in part " ... Incident Reviewed By IDT

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6014385	A. BUILDING: _____ B. WING _____	04/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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
S9999	Continued From page 3 (Interdisciplinary Team): root cause analysis consistent c (with) (R39) attempting to stand up from recliner et (and) ambulate c walker, c (R39) observed lying prone on floor in front of recliner ..." On 4/4/25 at 11:37 AM, V7 (Nurse Practitioner) said she was familiar with R39. V7 said R39's October 2024 fall could have caused the fracture because R39 has severe osteopenia and R39 has had fractures in the past. On 4/4/25 at 10:00 AM, V1 (Administrator) said R39's fall with fracture was not reported because the fracture was pathological. V1 said the facility was not able to find R39's folder with the 10/26/24 fall investigation and so V1 typed an Incident Review Summary. R39's Incident Review Summary documented in part " ...Incident Review Summary ...(R39's name) 10/24 ... Resident rose independently from recliner, to toilet, and began to walk with walker towards restroom Nurse (V9) heard the clattering and fall and found (R39) on floor (R39) had not utilitized [sic] call light for assistance. Wrist began to swell, and resident was sent to emergency room. Resident has significant osteopenia, as well as history of multiple fractures from her treatments for cancer and other co morbidities. Review of documentation indicated that the wrist had likely pathogenically/ benignly fractured on the weight bearing activity of utilizing it to transfer and ambulate with walker ..." On 4/4/25 at 11:30 AM, V1 said the facility did not have a fall policy. V1 stated "I don't think we have any policy on when to do what assessments or what to do after a fall." V1 said the facility did not have a policy pertaining to reportable incidents. V1 said the facility did not report R39's fall with	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6014385	A. BUILDING: _____ B. WING _____	04/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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
S9999	Continued From page 4 fracture because the facility thought the fall was due to the fracture not the fracture was due to the fall. V1 stated "we thought (R39) was ambulating and her wrist fractured and that is what caused the fall." (C) Statement of Licensure Findings: 2 of 2 300.610a) 300.1620a) 300.3220f) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.1620 Compliance with Licensed Prescriber's Orders a) All medications shall be given only upon the written, facsimile, or electronic order of a licensed prescriber. The facsimile or electronic order of a licensed prescriber shall be authenticated by the licensed prescriber within 10 calendar days, in accordance with Section 300.1810. All orders shall have the handwritten signature (or unique identifier) of the licensed prescriber. (Rubber stamp signatures are not acceptable.) These medications shall be	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6014385	A. BUILDING: _____ B. WING _____	04/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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
S9999	Continued From page 5 administered as ordered-by the licensed prescriber and at the designated time. Section 300.3220 Medical Care f) All medical treatment and procedures shall be administered as ordered by a physician. All new physician orders shall be reviewed by the facility's director of nursing or charge nurse designee within 24 hours after such orders have been issued to assure facility compliance with such orders. (Section 2-104(b) of the Act) These Regulations were not met as evidenced by: Based on observation, interview, and record review, the facility failed to provide pain medications per physician's orders for 1 (R251) of 2 residents reviewed for pain management in the sample of 40. This failure resulted in R251 becoming tearful and experiencing increased pain. Findings Included: R251's Resident Face Sheet documented an admission date of 3/24/25. This same document listed diagnoses including other specified disorders of bone density and structure, other site, osteopenia of spine, rheumatoid arthritis, unspecified, unilateral primary osteoarthritis, right knee, bilateral primary osteoarthritis of hip, and primary osteoarthritis, right shoulder. R251's Care Plan documented a focus area of "Problem: Dx (diagnoses) of Rheumatoid arthritis, osteoarthritis/right knee, and osteoarthritis/right shoulder puts her at risk for pain" with a start date	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6014385	A. BUILDING: _____ B. WING _____	04/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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
S9999	Continued From page 6	S9999		

of 03/25/2025. Interventions documented included "administer pain medications as ordered. Monitor for side effects" with start date of 3/25/2025.

R251's April 2025 Physicians Order Report documented orders for hydrocodone-acetaminophen 7.5-325 mg (milligrams). One tablet by mouth every 4 hours for pain-prn (as needed) with a start date of 3/24/2025.

R251's Medication Administration History report dated 3/24/25 to 4/3/2025 documented hydrocodone-acetaminophen 7.5-325 mg. One tablet by mouth given on 4/3/25 at 1:42 AM. The same report documents R251's pain was rated at an 8 out of 10 on the pain scale before the pain medication and 0 out of 10 on the pain scale after the pain medication.

On 04/03/25 08:28 AM, V2 (Infection Preventionist) and V3 (Registered Nurse/RN) were observed entering R251's room to administer AM medications. R251 was observed notifying V2 that she had asked for her hydrocodone-acetaminophen 2.5 hours ago. V2 and V3 both stated to R251 that she is scheduled for this medicine every 12 hours at 7:00 AM, she does not have an order for every 4 hours and apologized that her medication was late. R251 stated that she does have an order that she can take this pain medication every 4 hours for pain, and she last took it at 2:00 AM this morning. R251 stated to V2 and V3 that she hurts all over and rated her pain at a 7 on a 1 to 10 pain scale. R251 was observed crying when talking to V2 and V3 and while taking her medications. R251 was observed to be alert and oriented to person, place, and time.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6014385	A. BUILDING: _____ B. WING _____	04/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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
S9999	Continued From page 7 On 4/3/2025 at 8:35 AM, V3 (RN) stated R251 does not have an order for hydrocodone-acetaminophen 7.5-325MG for every 4 hours as needed. On 4/3/2025 at 9:06 AM, V2 stated R251 did have an order for hydrocodone-acetaminophen 7.5-325MG every 4 hours as needed and there was a communication breakdown between staff. On 4/3/2025 at 9:17 AM, R251 is alert and oriented to person, place, and time. R251 stated she did notify staff members at 6:00 AM this morning that she had been in pain and wanted her pain medication. R251 stated, upon waking up she is a 5 out of 10 on the pain scale is her normal and she tries to stay ahead of hurting more. R251 stated she does get her hydrocodone-acetaminophen 7.5-325MG for every 4 hours as needed and the last time she had it was around 2:00 AM this morning. On 4/3/2025 at 9:52 AM, V4 (Certified Nurse Assistant/CNA) stated R251 did report to her at 6:00 AM that she wanted her pain medication. V4 stated she notified V3 (RN) while she was in report that R251 was requesting her pain medication. V4 stated that V3 did respond back to her by saying "ok'. On 4/4/2025 at 8:33 AM, V7 (Nurse Practitioner) stated her expectations are for the nursing staff to administer medications based on physician's order. V7 stated that R251 did have a physician's order for hydrocodone-acetaminophen 7.5-325MG for every 4 hours as needed and scheduled every 12 hours. V7 stated that 2.5 hours after R251 requested her pain medication was not an appropriate time frame to administer	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6014385	A. BUILDING: _____ B. WING _____	04/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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
S9999	Continued From page 8 the medication. The facility policy titled "Pain Management" (revised 3/03/22) documented under "Policy: The facility is dedicated to the philosophy that all residents should be as free of pain as possible, through a combination of medical intervention and functional therapy. Purpose: To identify residents experiencing pain to establish control of pain to the resident's satisfaction and to relieve related symptoms." (B)	S9999		