(X3) DATE SURVEY

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES

(X1) PROVIDER/SUPPLIER/CLIA

AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED		
		IL6014385	B. WING		01/12/2024		
PARKWAY MANOR 3116 WILI			DDRESS, CITY, STATE, ZIP CODE  LIAMSON COUNTY PARKWAY  , 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 SHOUL CROSS-REFERENCED TO THE APPROPERTION OF THE APPROPERTION (CROSS)	D BE COMPLETE		
S 000	Initial Comments		S 000				
	Annual Health Surv	ey					
S9999	Final Observations		S9999				
	Statement of Licens 300.690a) 300.690b) 300.690c)	sure Violations:					
	Section 300.690 In	cidents and Accidents					
	reports of each incidence resident that is not to resident's condition descriptive summar affecting a resident	I maintain a file of all written dent and accident affecting a che expected outcome of a or disease process. A cy of each incident or accident shall also be recorded in the urse's notes of that resident.					
	serious incident or a Section, "serious" n	I notify the Department of any accident. For purposes of this neans any incident or accident I harm or injury to a resident.					
	Regional Office with reportable incident or accident resident, the facility law enforcement punotify the Regional purposes of this Se Office by phone onl Department represephone that the requirement of the punction of the purpose of the second of the purpose of the second of the purpose of	Ill, by fax or phone, notify the nin 24 hours after each or accident. If a reportable results in the death of a shall, after contacting local resuant to Section 300.695, Office by phone only. For the ction, "notify the Regional y" means talk with a entative who confirms over the irement to notify the Regional is been met. If the facility is the Regional Office, it shall ent's toll-free complaint registry					
Oinnia Danna	tment of Public Health		Į.				

(X2) MULTIPLE CONSTRUCTION

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

**Electronically Signed** 

(X6) DATE TITLE 01/31/24

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Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		IL6014385	B. WING		01/	12/2024	
NAME OF PROVIDER OR SUPPLIER STREET ADD			DDRESS, CITY, STATE, ZIP CODE  LIAMSON COUNTY PARKWAY				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETE DATE	
S9999	hotline. The facility summary of each re to the Department of occurrence.  These REQUIREM evidenced by:  Based on interview failed to notify the Formal Department of Public Incident with seriou residents reviewed.  The findings include R35's face sheet do admitted to the facilincluding multiple for disruption of pelvic for fracture with rour obstructive pulmons symptoms and sign following other nonthemorrhage.  R35's "Event Report documents that R33 next to bed, bare for light on bed side tall clutter. Res (reside head. No visible in Resident states she privacy curtain to go slid and fell to floor. Lower Extremity) parts of the progression of the prog	shall send a narrative eportable accident or incident within seven days after the ENTS were not met as  and record review, the facility Regional Office at IDPH (Illinois ic Health) of a Reportable in incident in the sample of 2 for falls in the sample of 41.  Execuments that R35 was lity on 3/17/22 with diagnoses ractures of pelvis with stable ring, subsequent encounter tine healing, chronic ary disease, unspecified, other involving cognitive functions traumatic intracranial  art" dated 9/9/23 at 11:55pm, was observed laying supine oted, adequate lighting, call pole next to bed. Room free of ent) states she did not hit her invies noted at this time. It was trying to move the or to the bathroom when she R35 complained of LLE (Left ain.					
	6:22am by V9 (LPN	l/Licensed Practical Nurse) ur, left hip and pelvis x-ray					

Illinois Department of Public Health

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Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		IL6014385	B. WING		01/1	2/2024	
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DDRESS, CITY, STATE, ZIP CODE				
PARKWAY MANOR			LIAMSON COUNTY PARKWAY				
0//0.15	CHMMADV CTA			DDOVIDED'S DI AN OF CORRECTION	<b>2N</b> I	()(5)	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPERTION OF T	D BE	(X5) COMPLETE DATE	
S9999	Continued From page 2		S9999				
39999	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		29999				

Illinois Department of Public Health

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