STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445387	A. Building B. Wing	09/20/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Parkway Health and Rehabilitation Center	200 South Parkway West Memphis, TN 38109

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38440 Based on policy review, video camera footage review, medical record review, observation, and interview, the facility failed to ensure adequate supervision to prevent neglect of vulnerable and confused residents for 2 of 10 sampled residents (Resident #293 and #294) reviewed for abuse and wandering. The facility's failure resulted in Immediate Jeopardy when Resident #293 willfully struck Resident #294 which resulted in multiple facial fractures and when Resident #294 was found locked in a chemical storage closet (housekeeping closet) unsupervised for approximately 1 hour. Resident #293 and #294 did not have adequate supervision and interventions were not implemented for these behaviors. Immediate Jeopardy (IJ) is a situation in which the provider's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident. The Administrator and Chief Director of Clinical Operations (CDCO/Director of Nursing) were notified of the Immediate Jeopardy for F-600 on 9/17/2021 at 2:03 PM, in the Omega Room. The facility was cited Immediate Jeopardy at F-600. The facility was cited F-600 at a scope and severity of J, which is Substandard Quality of Care. The Immediate Jeopardy was effective from 7/8/2021 through 9/19/2021. An acceptable Removal Plan, which removed the immediacy of the jeopardy, was received on 9/19/2021 at 12:16 PM, and was validated onsite by the surveyors on 9/19/2021 and 9/20/2021 through review of root cause analysis, in-services, audits, and staff interviews conducted. The findings include: (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445387	A. Building B. Wing	09/20/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Parkway Health and Rehabilitation Center	200 South Parkway West Memphis, TN 38109

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the facility's policy titled, Abuse Prevention, revised on 3/1/2018, revealed .The resident has the right to be free from verbal, sexual, physical and mental abuse, corporal punishment and involuntary seclusion. The resident has the right to be free from mistreatment, neglect and misappropriation of property . This facility will establish an environment .that treats each resident with respect and dignity .Physical abuse . includes hitting .Neglect .means failure to provide goods and services necessary to avoid physical harm, mental anguish or mental Illness .when abuse, neglect or exploitation is suspected the Licensed Nurse should .Notify the Director of Nursing and Administrator .Complete an incident report and initiate an immediate investigation to prevent further potential abuse .Obtain witness statements following incident policies .Monitor and document the resident's condition .Document actions taken .in the medical record .It is the responsibility of all staff to provide a safe environment for the residents .Examples of ways to protect a resident from harm during an investigation of abuse, neglect and exploitation may include .Temporary one on one supervision .When suspicion or reports of abuse, neglect or exploitation occur, an investigation is immediately warranted .Interview with the involved resident, if possible and document all responses. If the resident is cognitively impaired, interview the resident several times to compare responses. Interview all witnesses separately .Obtain witness statements . Review of the facility's policy titled, Elopement Of Resident, dated 9/1/2018, revealed .Should an employee discover that a resident is missing .If not located in 15 minutes .Notify the Administrator and the Director of Nursing Services .Notify the attending physician .Determine the time and location the resident was last seen . Once the Resident is Located .The resident will be assessed by M.D. [Medical Doctor] and documented .The Charge Nurse will complete an Incident Report .The Administrator/Director of Nursing Services will notify the Department of Health per State Regulations .A complete and thorough root-cause analysis of the elopement should be done .reviewed at the next QAPI [Quality Assurance Performance Improvement] meeting . Review of the facility's policy titled, Unsafe Wandering-Elopement Risk Policy, dated 9/21/2017, revealed Every effort will be made to prevent unsafe wandering .Should an elopement episode occur, an incident report will be completed .If an elopement episode occurs, a monitoring schedule will be implemented to ensure resident safety .The resident's care plan will be updated as to the implementation of the monitoring . Review of the medical record, revealed Resident #293 was admitted to the facility on [DATE] with diagnoses of Congestive Heart Failure, Chronic Obstructive Pulmonary Disease, Diabetes, Hypertension, and Schizophrenia. Review of the admission Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #293 had a Brief Interview for Mental Status (BIMS) score of 4 which indicated he was severely cognitively impaired for decision making, had no physical behaviors, wandered on 1-3 days of the 7-day assessment period, and was able to transfer and walk without physical assistance from staff. Review of a Skilled Evaluation for Resident #293 dated 7/8/2021 at 8:40 PM, revealed .Resident does not obey commands .Resident is confused .Mood is pleasant, no unwanted behaviors witnessed . Review of an SBAR (Situation, Assessment, Background, Recommendation) note dated 7/9/2021 at 3:18 AM, revealed, .The Change In Condition/s reported on this CIC [Change In Condition] Evaluation are/were: Behavioral symptoms .Physical aggression . (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445387	A. Building B. Wing	09/20/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Parkway Health and Rehabilitation Center	200 South Parkway West Memphis, TN 38109

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of a Behavior Note dated 7/9/2021 at 1:31 PM, revealed Resident #293 made the Social Worker (SW) aware of the physical altercation between Resident #293 and Resident #294 when Resident #294 entered Resident #293's room and made crude comments to him. Resident #293 asked Resident #294 to leave the room. When Resident #294 did not leave the room, Resident #293 .gave him [Resident #294] a karate chop [on the side of his head] because he disrespected me [Resident #293] Review of the medical record, revealed Resident #294 was admitted to the facility on [DATE] with diagnoses of Cellulitis, Hypertension, Benign Prostatic Hyperplasia, History of Falling, Vascular Dementia, Osteoarthritis, Age Related Debility, and Protein Calorie Malnutrition. Review of the admission MDS dated [DATE], revealed Resident #294 had a BIMS of 3, which indicated he was severely cognitively impaired for decision making, wandered on 1-3 days of the 7-day assessment period, and required limited physical assistance with transfer and ambulation. Review of the Care Plan dated 6/24/2021, revealed, Resident #294 had wandering behavior and wore a wander guard (a mechanical bracelet device that will cause the door to alarm when the resident gets close to the door) bracelet that was initiated on 7/13/2021. Review of the Elopement Evaluation dated 6/28/2021, revealed Resident #294 was a wanderer, had a history of attempting to leave the facility without informing staff, and had verbally expressed the desire to go home. Review of an undated statement written by Licensed Practical Nurse (LPN) #1 revealed a Resident contacted her and stated Resident #293 hit Resident #294. When LPN #1 asked Resident #293 if he struck Resident #294, he denied hitting the resident, but admitted to .pushing [Named Resident #294] down . LPN #1 stated Resident #294 had no injuries at that time and the resident remained at the desk in view of the staff. Review of a Nurse's Note dated 7/9/2021 at 4:40 PM, revealed that Resident #294's face was swollen. The right eye was swollen with purple and dark red bruising. This was the first documentation of Resident #294's injuries from the altercation that occurred on 7/8/2021. Review of a Nurse's Note dated 7/9/2021 at 11:04 PM, revealed Resident #294 returned from the hospital emergency room to the facility on [DATE] at 8:38 PM with diagnoses of .comminuted fractures [breakage of the bone into more than two fragments] involving the anterior and lateral walls of the left maxillary sinus and additional fractures through the lateral wall of the left orbit and left zygomatic bone [the bone at the upper, outer part of the face forming the prominence of the cheek] (Multiple Facial Fractures) . Review of the video footage provided by the facility revealed that on 7/8/2021 at 5:38 PM, the doors of the 100-111 Hall were closed and there were no staff present in the hall. Resident #294 ambulated out of his room into the hallway. At 5:39 PM, Resident #294 ambulated toward the room across the hall and was struck on the left side of the face by Resident #293, knocking Resident #294 to the floor. Resident #294 was in the middle of the hallway on his right side. He sat up and appeared to be trying to get to a standing position when the video ended. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445387	A. Building B. Wing	09/20/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Parkway Health and Rehabilitation Center	200 South Parkway West Memphis, TN 38109

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of a facility's investigation dated 7/9/2021, revealed .After reviewing the camera it is found that residents [Residents #293 and Resident #294] .were having an argument .[Named Resident #293] struck [Named Resident #294] in the face .In order to keep this from happening again the said Residents were on the same wing together but [Resident #294] is being moved to a separate wing to be monitored closer. Resident [#293] is sent to a local Psychiatric Hospital .Resident [#294] returned with dx [diagnosis] of comminuted fractures involving the anterior and lateral walls of the left maxillary sinus and additional fractures throughout the lateral wall of the left orbit and left zygomatic bone . The facility was unable to provide documentation that Resident #293 was monitored, or increased supervision was provided after the altercation to prevent further physically aggressive behaviors toward Resident #294 or any other residents from the time of the incident on 7/8/2021 at 5:39 PM, until he was transferred out of the facility on 7/9/2021 at 5:30 PM. During an interview on 9/16/2021 at 11:08 AM, the Administrator was asked to describe the investigation related to the altercation between Resident #293 and Resident #294. The Administrator stated, .The night that [Named Resident #293] and [Named Resident #294]'s altercation [occurred], it wasn't witnessed .a resident reported the incident to the nurse .at first he [Resident #294] had no injuries and when the next shift came on, he had started bruising . The Administrator was asked if there were any interventions implemented to protect the other residents in the facility after the altercation occurred. The Administrator stated, .They were separated and [Named Resident #293] was actually transferred to psych [psychiatric facility] [the next day] . During an interview on 9/16/2021 at 1:54 PM, the Regional Director of Clinical and Operations (RDCO) was asked if she was aware of the incident between Resident #293 and Resident #294 on 7/8/2021. The RCDO stated, I am familiar. The RDCO was asked what interventions were implemented to prevent Resident #294 from harming other residents. The RDCO stated, I know the aggressor .took him to his room where the door would be closed, they were rounding on him to make sure he stayed in his room and wasn't in contact with other residents .the next day he was transferred out. The RDCO confirmed there was no documentation of close supervision of Resident #294 after the incident and there was no further investigation. During a telephone interview on 9/16/2021 at 9:00 PM, LPN #1 was asked if the altercation between Resident #293 and Resident #294 on 7/8/2021 was witnessed. LPN #1 stated, No, I did not. LPN #1 was asked where Resident #293 was located following the altercation with Resident #294. LPN #1 stated, .in his room. He went to bed. LPN #1 confirmed that Resident #293 did not have any additional monitoring or increased supervision after the incident. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445387	A. Building B. Wing	09/20/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Parkway Health and Rehabilitation Center	200 South Parkway West Memphis, TN 38109

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 9/17/21 at 8:47 AM, LPN #4 was asked about the incident between Resident #293 and Resident #294 on 7/8/2021. LPN #4 stated when she arrived for work the next morning, the nurse stated another resident observed Resident #293 punch Resident #294 in the face. When she saw Resident #294's bruising she contacted the Nurse Practitioner to obtain orders to send the resident to the hospital for evaluation to .make sure nothing was broken or fractured . LPN #4 was asked if the bruising appeared severe enough to think there was a fracture. LPN #4 stated, It was bad . She further stated Resident #293 was also sent out for an evaluation. LPN #4 was asked if Resident #293 had any injuries and she replied, He did not. LPN #4 was asked if Resident #293 remained in his room all day the day of the incident. LPN #4 stated, He did, I asked him to stay in his room. LPN #4 was asked how often staff monitored Resident #293 to assure he was in his room. LPN #4 stated, .at least every 2 hours but in that situation, I believe I went down there every hour. [Named Resident #293] liked to walk . LPN #4 confirmed neither resident was evaluated by a physician. Resident #293 was not evaluated by psychiatric services prior to being transferred out of the facility on 7/9/2021. During a telephone interview on 9/17/2021 at 3:01 PM, the Medical Director was asked if a resident that was being transferred out of the facility after a violent behavior should be monitored until they were transferred. The Medical Director stated, Yes. During an interview on 9/17/2021 at 3:59 PM, the Administrator was asked what involvement he had in the altercation between Resident #293 and #294. The Administrator stated, I'm the Abuse Coordinator so they called me . The Administrator was asked when he was notified. The Administrator stated, Not until the next day. The Administrator was asked if he provided any instructions as to what the staff should do regarding this situation and the Administrator stated, I didn't . During an interview on 9/17/2021 at 5:37 PM, the RDCO confirmed she was the acting DON from May 5/25/2021-7/12/2021 and was working the day Resident #293 struck Resident #294 in the face, knocked him to the floor, and Resident #294 sustained multiple facial fractures. The RDCO confirmed she did not provide guidance to the Administrator and staff regarding the altercation between Resident #293 and Resident #294. Review of a Nurse's Note dated 7/13/2021 at 12:00 AM, revealed [Named Resident #294] wonders [wanders] the building day/night and was last seen by nurse before her lunch break after 8pm [8:00 PM on 7/12/2021]. Upon return from nurses [nurse's] lunch break, the CNA [Certified Nursing Assistant] asked nurse had she saw [seen] resident because she was ready to change him and get him ready for bed. Nurse responded No. After about 30 min [minutes], CNA informed nurse that she still was unable to find resident [Resident #294] and need [needed] help locating resident. Nurse and CNA began looking room to room calling residents [resident's] name trying to locate him. After about 15/20 mins [15 to 20 minutes] of looking we called a DR [doctor] Find Me [code for elopement or missing residents] for all employees to help locate resident. Nurse contacted Nurse Manager and informed her that we had been looking for resident for about any [an] hour with no progress. Nurse Manager called Administrator and DON to inform them about the situation as all in-house staff continues to search the entire inside and outside. Nurse Manager arrived the search continued. As nurses and Nurse manager were making their way back up the East Wing towards the nursing station we heard a call for help coming from the housekeeping closet. Resident had got himself locked into the closet and was calling for help out. Administrator informed Nurse Manager on the location to of housekeeping's closet keys so we could unlock door to get resident out. Opening closet door nurse observed resident sitting on floor. We assisted resident out and evaluated. No signs of injury . (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445387	A. Building B. Wing	09/20/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Parkway Health and Rehabilitation Center	200 South Parkway West Memphis, TN 38109

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The facility was unable to provide an incident report, investigation of the incident, or documentation of monitoring implemented to ensure Resident #294's safety. Observation of the housekeeping closet on the East Hall on 9/15/2021 at 1:14 PM and 1:25 PM, revealed the door was unlocked and had an over-head shelf that contained 2 (1 quart) containers of antibacterial cleaner, 1 (1 quart) container of a liquid cream cleanser, and 1 (1 quart) bottle of toilet bowl cleaner on the shelf. Observation of the housekeeping closet on the [NAME] hall on 9/15/2021 at 1:21 PM, revealed the door was unlocked and had an over-head shelf that contained 1 (1 quart) bottle of furniture cleaner and 1 (1 quart) bottle of floor cleaner on the shelf. During an interview on 9/15/2021 at 5:17 PM, LPN #2 was asked how staff monitored wandering residents. LPN #2 stated, When we figure out, they are [wanderers] we put wander guards on them .helps us with doorway or exiting .as far as monitoring on a day-to-day basis we do the best we can . LPN #2 was asked if any doors to rooms or offices were left unlocked making it accessible for a resident to wander into the room and not be easily observed by any staff. LPN #2 stated, .there was an incident when there was a door that was not secured and locked and a resident got into it .I think it was a housekeeping closet and I think the housekeeper left it unlocked or didn't close it all the way .I thought that was like an electrical closet . LPN #2 was asked who located Resident #294 when the resident was locked in the housekeeping closet. LPN #2 stated, .It was a group of us walking up the hall .heard him yelling .our Unit Manager was walking past the door and said she thought he was in there .we knocked, and he knocked back . LPN #2 was asked if Resident #294 was injured when he was located and she stated, No . LPN #2 further stated the staff searched for Resident #294 for .probably an hour . During an interview on 9/15/2021 at 5:49 PM, the Director of Nursing (DON) was asked if she could recall the incident with Resident #294 on 7/12/2021. The DON stated, Yes .I received a call saying they could not find the resident and I was headed here .but he was found in a closet .In a maintenance or storage closet, I think it was maintenance or housekeeping .one of them down on the East Hall . The DON was asked if these rooms should be unlocked. The DON stated, No. During an interview on 9/16/2021 at 10:49 AM, LPN #3/Unit Manager was asked about the incident where Resident #294 was missing. LPN #3/Unit Manager stated, I was actually on vacation but I was in the area . they [staff] called me on how to move forward, I'm down the street, said we've been looking for [Named Resident #294] about 30 minutes .he was in the Housekeeper's closet [Chemical Storage Closet] .on East [Hall] .I could hear him saying open the door or something like that . LPN #3/Unit Manager was asked was the door locked when they located the resident. LPN #3/Unit Manager stated, It was, I had to locate a key. LPN #3/Unit Manager was asked if that closet was usually unlocked. LPN #3/Unit Manager stated, No, it's supposed to be locked . LPN #3/Unit Manager was unable to recall if chemicals were stored in the closet the night of the incident. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445387	A. Building B. Wing	09/20/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Parkway Health and Rehabilitation Center	200 South Parkway West Memphis, TN 38109

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 9/16/2021 at 11:11 AM, the Administrator was asked when he was made aware Resident #294 went missing. The Administrator stated, .I got a call maybe if I had to guess, in the 9 o'clock hours, called maybe 10 minutes later the resident had been located . The Administrator was asked if there had been an investigation of the incident and were witness statements obtained. The Administrator stated, .I told them to put an incident report in PCC [the electronic medical record] in the system .then we did the QA [Quality Assurance] on our protocol . The Administrator was asked why the facility had failed to investigate the incident of a missing resident. The Administrator stated, .Because the Unit Manager was there and she had the team to write the note in the system .found the door was actually locked but it wasn't latched, closed, he didn't have the capacity to lock or unlock a door, when he went in it slammed behind him and he couldn't get out . The Administrator was asked when the resident was last seen prior to being identified as missing. The Administrator stated, .I talked to [Named LPN #3/Unit Manager] and they [the staff] weren't able to tell her .in my mind great, he wasn't outside, he wasn't hit, nobody brought him to us .they told me he was in the chemical [housekeeping] closet . The Administrator was asked if he looked back at the video camera footage to see how long the resident had been in the storage room. The Administrator stated, No. During an interview on 9/16/2021 at 1:54 PM, the RDCO was asked what interventions were implemented for Resident #294 after he was found locked in the housekeeping closet. The RDCO stated, I wanted him to have a trauma assessment, talked to the doctor .Safety Committee . The RDCO confirmed no in-services were provided to staff related to the incident. During an interview on 9/16/2021 at 3:00 PM, the RDCO provided documentation that the incident that occurred on 7/12/2021 was discussed by the Safety Committee on 8/25/2021, 6 weeks after the incident. During a telephone interview on 9/17/2021 at 3:01 PM, the Medical Director was asked if he was aware of an incident regarding a missing resident. The Medical Director stated, Yes, I was, it was brought up [in a Quality Assurance meeting] and it wasn't handled the way it should have been, we talked about that. The Medical Director was asked if he made any recommendations on how it should have been handled. The Medical Director stated, Earlier notification of the Physician or Nurse Practitioner on call, Administrator, DON, try to get people sent out as soon as possible, one with injuries make sure to notify the family right away .I guess the people working that night did not understand that . During an interview on 9/17/2021 at 3:59 PM, the Administrator was asked what involvement he had when there was a missing resident. The Administrator stated, .the staff called to notify me that they had not seen him [Resident #294] .I would have never thought he was in a chemical [housekeeping] closet. The Administrator stated the resident was located before he was able to get to the facility. The Administrator was asked if there were any in-services conducted or staff education done after this incident to remind the staff to keep the doors locked. The Administrator stated, There was not . Refer to F-609, F-610, and F-689. The surveyors verified the removal plan by: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445387	A. Building B. Wing	09/20/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Parkway Health and Rehabilitation Center	200 South Parkway West Memphis, TN 38109

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	1. On 9/17/2021, a Root Cause Analysis was completed and found the Abuse Coordinator was not notified of the resident-to-resident altercation timely, the Charge Nurse failed to document immediate interventions, and failed to document monitoring of residents after the resident-to-resident altercation. The surveyors reviewed the Root Cause Analysis conducted by the RDCO. 2. On 9/17/2021, the RDCO re-educated the Administrator, CDCO (DON), Assistant CDCO, Staff Development Coordinator (SDC), and Unit Managers on Abuse and Neglect Prevention, Resident Rights, Elder Justice Act, Storage of Medications, Biologicals, and Chemicals, Elopement, and Behavior Management and Monitoring. The surveyors reviewed the in-service education provided and interviewed the Administrator, SDC, and DON. 3. On 9/17/2021 and 9/18/2021, 100 percent (%) of all current resident and or resident representatives (if resident is cognitively impaired) were re-educated on the Abuse & Neglect Prevention Policy, Resident Rights and Elder Justice Act. The surveyors interviewed alert and oriented residents and reviewed the medical record for family notification. 4. On 9/17/2021 and 9/18/2021, staff were re-educated on Abuse & Neglect Prevention, Resident's Rights, Elder Justice Act, and Elopement. All licensed nurses were educated on Abuse Reporting and Investigation Guidelines, documentation guidelines, Behavior Management and Monitoring, and Elopement policy. Employees will not be allowed to work until in-services are completed. The surveyors reviewed the in-services and interviewed staff on all shifts. 5. The Administrator and Social Services will monitor and audit all reports of alleged abuse and neglect weekly for 8 weeks, then monthly for 3 months. The surveyors reviewed the audits and interviewed the Administrator. 6. The Administrator will submit all reports of alleged abuse weekly to the RDCO to review to ensure the process meets regulatory guidelines. The surveyors interviewed the RDCO. The facility's noncompliance of F-600 continues at a scope and severity of D for monitoring the effectiveness of the corrective actions. The facility is required to submit a Plan of Correction.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445387	A. Building B. Wing	09/20/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Parkway Health and Rehabilitation Center	200 South Parkway West Memphis, TN 38109

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38440 Based on policy review, medical record review, and interview, the facility failed to report an incident of a missing resident for 1 of 7 sampled residents (Resident #294) reviewed with wandering behaviors. The facility's failure to report incidents of missing residents and neglect to the State Survey Agency and other appropriate agencies resulted in Immediate Jeopardy when Resident #294 was missing and found locked in a chemical storage (housekeeping) closet after approximately one hour without staff knowledge of the location of the resident. Immediate Jeopardy (IJ) is a situation in which the provider's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident. The Administrator and the Chief Director of Clinical Operations (CDCO/Director of Nursing) were notified of the Immediate Jeopardy on 9/17/2021 at 2:04 PM, in the Omega Room. The facility was cited Immediate Jeopardy at F-609. The facility was cited F-609 at a scope and severity of J, which is Substandard Quality of Care. The Immediate Jeopardy for F-609 was effective from 7/12/2021 through 9/19/2021. An acceptable Removal Plan, which removed the immediacy of the Jeopardy, was received on 9/19/2021 at 12:16 PM, and was validated onsite by the surveyors from 9/19/2021 and 9/20/2021 through observations, review of audits, meeting minutes, and staff interviews. The findings include: Review of the facility's Abuse Prevention Policy, revised on 3/1/2018, revealed .The resident has the right to be free from mistreatment, neglect and misappropriation of property . Review of the facility's policy titled, Elopement Of Resident, dated 9/1/2018, revealed .Should an employee discover that a resident is missing .If not located in 15 minutes .Notify the Administrator and the Director of Nursing Services .Notify the resident's representative .Notify the attending physician .Notify law enforcement officials .The Charge Nurse will complete an Incident Report .The Administrator/Director of Nursing Services will notify the Department of Health per State Regulations . Review of the facility's policy titled, Incident Report - Documentation, Investigating, And Reporting, revised 10/2019, revealed .The Administrator/Director of Nursing will notify the appropriate Regulatory Agency in accordance with reporting guidelines in the event the incident is reportable . (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445387	A. Building B. Wing	09/20/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Parkway Health and Rehabilitation Center	200 South Parkway West Memphis, TN 38109

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the facility's Quality Assurance Performance Improvement (QAPI) document, dated 8/25/2021, revealed .Elopement risk and incident discussed with the QAA [Quality Assurance Agency] team .Resident Missing, nurses could not find him. Charge Nurse did not notify the Admin [Administrator] in a timely man [manner] .Root Cause: Left safe area . Review of the medical record, revealed Resident #294 was admitted to the facility on [DATE] with diagnoses of Cellulitis, Hypertension, Benign Prostatic Hyperplasia, History of Falling, Vascular Dementia, Osteoarthritis, Age Related Debility, and Protein Calorie Malnutrition. Review of the Nurse's Note dated 7/13/2021, at 12:00 AM, revealed, [Named Resident #294] who wonders [wanders] the building day/night and was last seen by nurse before her lunch break after 8pm [8:00 PM on 7/12/2021]. Upon return from nurses [nurse's] lunch break, the CNA [Certified Nursing Assistant] asked nurse had she saw [seen] resident because she was ready to change him and get him ready for bed. Nurse responded No. After about 30 min [minutes], CNA informed nurse that she still was unable to find resident and need [needed] help locating resident. Nurse and CNA began looking room to room calling residents [resident's] name trying to locate him. After about 15/20 mins [15 to 20 minutes] of looking we called a DR [doctor] Find Me [code for elopement or missing resident] for all employees to help locate resident. Nurse contacted Nurse Manager and informed her that we had been looking for resident for about any [an] hour with no progress [unable to locate Resident #294]. Nurse Manager called Administrator and DON to inform them about the situation as all in-house staff continues to search the entire inside and outside. Nurse Manager arrived the search continued. As nurses and Nurse manager were making their way back up the East Wing towards the nursing station we heard a call for help coming from the housekeeping closet. Resident had got himself locked into the closet and was calling for help out. Administrator informed Nurse Manager on the location of housekeeping's closet keys so we could unlock door to get resident out. Opening closet door nurse observed resident sitting on floor. We assisted resident out and evaluated. No signs of injury .Resident unable to explain what happened . This incident of missing resident on 7/12/2021, was not reported to the State Survey Agency and APS. During an interview on 9/15/2021 at 6:11 PM, the Director of Nursing (DON) confirmed the missing resident incident was not reported to the Ombudsman, the State Survey Agency, and APS. During an interview on 9/16/2021 at 10:49 AM, Licensed Practical Nurse (LPN) #3/Unit Manager stated, . they [staff] called me .said we've been looking for [Resident #294] for about 30 minutes .I am down the street .I pulled up .I called them [The Administrator and the Regional Director of Clinical and Operations (RDCO), the acting DON at the time] .she [RDCO] said I am on the way .before they [RDCO and the Administrator] could make it I actually found him .ha was in the Housekeeper's closet [Chemical Storage Closet] .on East [Hall] .he was sitting [on the floor] .he was just confused . LPN #3 confirmed the door was locked from the inside and she had to locate a key to unlock it. LPN #3 was asked if chemicals were stored in the closet. LPN #3 stated, I do not recall .I remember looking to see if there were open containers, but I do not recall. LPN #3 confirmed the door was supposed to be locked. During an interview on 9/16/2021 at 1:54 PM, The RDCO confirmed she was the acting DON at the time of the incident with Resident #294. The RDCO confirmed the incident when Resident #294 was locked in the chemical storage closet was not reported to the State Survey Agency and APS. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445387	A. Building B. Wing	09/20/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Parkway Health and Rehabilitation Center	200 South Parkway West Memphis, TN 38109

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 9/17/2021 at 3:59 PM, the Administrator was asked why he did not investigate or report the incident with Resident #294. The Administrator stated, Being that I can't report what I don't know, I did not [investigate or report the incident] . The Administrator was asked if an unsupervised resident wandered into an unsafe environment, should that incident be investigated and reported. The Administrator stated, Per our policy, yes. Refer to F-600, F-610, and F-689. The surveyors verified the Removal Plan by: 1. On 9/17/2021, a Root Cause Analysis (RCA) was completed. The Charge Nurse was suspended for 4 days for failure to notify the Administrator and the RDCO when the incident occurred. The RDCO re-educated the Administrator, the DON, Assistant Chief Director of Clinical Operation, Staff Development Coordinator, and unit Managers on Abuse and Neglect Prevention, Resident's Rights, the Elder Justice Act, Reporting Guidelines, Storage of Medications, Biological and Chemicals, Elopement, Behavior Management & Monitoring. The RCA was reviewed by the surveyors and staff interviews were conducted with Administrative staff, the Staff Development Coordinator, and Unit Managers. 2. On 9/17/2021 and 9/18/2021, all current resident and/or resident representatives for cognitively impaired residents were re-educated on Abuse & Neglect Prevention, Resident's Rights, and the Elder Justice Act. The surveyors interviewed alert and oriented residents and reviewed the medical record for family notification. 3. On 9/17/2021 and 9/18/2021, staff were re-educated on Abuse & Neglect Prevention, Resident's Rights, the Elder Justice Act, Abuse Reporting Guidelines, and Elopement. Employees will not be allowed to return to work until the in-services are completed. The surveyors reviewed the in-services and interviewed staff on all shifts. 4. On 9/17/2021 and 9/18/2021, all licensed nurses were educated on Abuse reporting guidelines, documentation guidelines, behavior management & monitoring, and elopement policy. Employees will not be allowed to return to work until in-services are completed. The surveyors reviewed the in-services and interviewed staff on all shifts. 5. The Administrator or DON will monitor, audit, and ensure all reports of alleged abuse are submitted to the appropriate state agency and report findings in the monthly QAPI meeting for 3 months or until compliance is achieved. The surveyors reviewed the audit log form and interviewed the Administrator and DON. 6. The RDCO will review all reports of alleged abuse weekly and ensure regulatory guidelines are met. The surveyors interviewed the RDCO. The facility's noncompliance of F-609 continues at a scope and severity of D for monitoring the effectiveness of the corrective actions. The facility is required to submit a Plan of Correction.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445387	A. Building B. Wing	09/20/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Parkway Health and Rehabilitation Center	200 South Parkway West Memphis, TN 38109

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38440 Based on policy review, video camera footage review, medical record review, observation, and interview, the facility failed to thoroughly investigate an incident of resident-to-resident abuse and a missing resident for 2 of 10 sampled residents (Resident #293 and #294) reviewed for abuse and wandering. The facility's failure resulted in Immediate Jeopardy when the facility failed to implement interventions to ensure the safety of other residents when Resident #293 willfully struck Resident #294, resulting in multiple facial fractures and when Resident #294 was missing for approximately 1 hour without staff knowledge and was found locked in a chemical storage (housekeeping) closet. Immediate Jeopardy (IJ) is a situation in which the provider's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident. The Administrator and Chief Director of Clinical Operations (CDCO)/Director of Nursing) were notified of the Immediate Jeopardy for F-610 on 9/17/2021 at 2:03 PM, in the Omega Room. The facility was cited Immediate Jeopardy at F-610. The facility was cited F-610 at a scope and severity of J, which is Substandard Quality of Care. The IJ was effective from 7/8/2021 through 9/19/2021. An acceptable Removal Plan, which removed the immediacy of the jeopardy, was received on 9/19/2021 at 12:16 PM, and was validated onsite by the surveyors on 9/19/2021 and 9/20/2021 through review of root cause analysis, in-services, and staff interviews conducted on all shifts. The findings include: Review of the facility's policy titled, Abuse Prevention, revised on 3/1/2018, revealed .The resident has the right to be free from verbal, sexual, physical and mental abuse, corporal punishment and involuntary seclusion. The resident has the right to be free from mistreatment, neglect and misappropriation of property . when abuse, neglect or exploitation is suspected the Licensed Nurse should .Notify the Director of Nursing and Administrator .Complete an incident report and initiate an immediate investigation to prevent further potential abuse .Obtain witness statements following incident policies .Monitor and document the resident's condition .Document actions taken .in the medical record .Examples of ways to protect a resident from harm during an investigation of abuse, neglect and exploitation may include .Temporary one on one supervision . When suspicion or reports of abuse, neglect or exploitation occur, an investigation is immediately warranted . Interview with the involved resident, if possible and document all responses. If the resident is cognitively impaired, interview the resident several times to compare responses. Interview all witnesses separately . Obtain witness statements . (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445387	A. Building B. Wing	09/20/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Parkway Health and Rehabilitation Center	200 South Parkway West Memphis, TN 38109

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the facility's policy titled, Elopement Of Resident, dated 9/1/2018, revealed .Should an employee discover that a resident is missing .If not located in 15 minutes .Notify the Administrator and the Director of Nursing Services .Notify the attending physician .Determine the time and location the resident was last seen . Once the Resident is Located .The resident will be assessed by M.D. [medical doctor] and documented .The Charge Nurse will complete an Incident Report .A complete and thorough root-cause analysis of the elopement should be done .reviewed at the next QAPI [Quality Assurance Performance Improvement] meeting . Review of the facility's Unsafe Wandering-Elopement Risk Policy, dated 9/21/2017, revealed Every effort will be made to prevent unsafe wandering .Should an elopement episode occur, an incident report will be completed .If an elopement episode occurs, a monitoring schedule will be implemented to ensure resident safety .The resident's care plan will be updated as to the implementation of the monitoring . Review of the facility's policy titled Incident Report - Documentation, Investigating, And Reporting, revised 10/2019, revealed .The Nurse Supervisor/Charge Nurse and/or department director or supervisor shall promptly initiate and document investigation of the accident or incident .The supervisor designee is to document the investigation of the event and the intervention put into place . Review of the medical record, revealed Resident #293 was admitted to the facility on [DATE] with diagnoses of Congestive Heart Failure, Chronic Obstructive Pulmonary Disease, Diabetes, Hypertension, and Schizophrenia. Review of the admission Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #293 had a Brief Interview for Mental Status (BIMS) score of 4, which indicated he was severely cognitively impaired for decision making, wandered on 1-3 days of the 7-day assessment period, and was able to transfer and walk without physical assistance from staff. Review of a Skilled Evaluation dated 7/8/2021 at 8:40 PM, revealed .Resident does not obey commands . Resident is confused .Mood is pleasant, no unwanted behaviors witnessed . Review of an SBAR (Situation, Assessment, Background, Recommendation), note dated 7/9/2021 at 3:18 AM, revealed The Change In Condition/s reported on this CIC [Change In Condition] Evaluation are/were: Behavioral symptoms .Physical aggression . Review of a Nurse's Note dated 7/9/2021 at 11:41 AM, revealed Licensed Practical Nurse (LPN) #1 was informed Resident #294 and Resident #293 had an altercation in the hallway of the East station and that Resident #293 hit Resident #294 with his fist. Resident #293 stated to LPN #1 he pushed Resident #294. Both residents were assessed and were reported to not have any physical injuries at that time. Review of a Behavior Note dated 7/9/2021 at 1:31 PM, revealed SW [Social Worker] informed that resident had a physical altercation with another resident .[Named Resident #293] said, I gave him [Resident #294] a karate chop because he disrespected me. [Named Resident #293] pointed to the side of his head when asked where he hit the other resident. [Named Resident #293] noted with dx [diagnosis] of dementia and schizophrenia . (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445387	A. Building B. Wing	09/20/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Parkway Health and Rehabilitation Center	200 South Parkway West Memphis, TN 38109

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the medical record, revealed Resident #294 was admitted to the facility on [DATE] with diagnoses of Cellulitis, Hypertension, Benign Prostatic Hyperplasia, History of Falling, Vascular Dementia, Osteoarthritis, Age Related Debility, and Protein Calorie Malnutrition. Review of the admission MDS dated [DATE], revealed Resident #294 had a BIMS of 3 which indicated he was severely cognitively impaired for decision making, wandered on 1-3 days of the 7-day assessment period, and required limited assistance with transfer and ambulation. Review of the video camera footage provided by the facility, revealed that on 7/8/2021 at 5:38 PM, the doors of the 100-111 hallway were closed and no staff were seen in the hall. Resident #294 ambulated out of his room into the hallway. At 5:39 PM, Resident #294 ambulated toward a room across the hall and was struck on the left side of his face by Resident #293 and the force of the blow knocked him to the floor. Resident #294 fell in the middle of the hallway on his right side. He then sat up and appeared to be trying to get to a standing position when the video ended. Review of a Nurse's Note for Resident #294 dated 7/9/2021 at 4:40 PM, revealed While making morning rounds with off-going nurse this writer cbserved [observed] resident's face swollen, right eye red swollen with purple and dark red bruising, per off-going nurse a resident to resident altercation happened . Review of a Nurse's Note for Resident #294 dated 7/9/2021 at 11:04 PM, revealed Resident returned back from [Named Hospital] @ 20:38pm [at 8:38 PM]. He returned with dx [diagnosis] of comminuted fractures [the bone was broken into more than 2 fragments] involving the anterior and lateral walls of the left maxillary sinus and additional fractures through the lateral wall of the left orbit and left zygomatic [the bone at the upper, outer part of the face forming the prominence of the cheek] bone (Multiple Facial Fractures) . Review of the facility's investigation dated 7/9/2021, revealed .After reviewing the camera it is found that residents [Resident #293 and #294] .were having an argument .[Named Resident #293] struck [Named Resident #294] in the face .In order to keep this from happening again the said Residents were on the same wing together but [Resident #294] is being moved to a separate wing to be monitored closer. Resident [#293] is sent to a local Psychiatric Hospital . [Resident #294] returned with a diagnosis of comminuted fractures involving the anterior and lateral walls of the left maxillary sinus and additional fractures throughout the lateral wall of the left orbit and left zygomatic bone . The facility was unable to provide documentation that interventions were implemented for Resident #293 to prevent further aggressive behaviors toward Resident #294 or other residents until he was transferred to a psychiatric facility on 7/9/2021 at 5:30 PM. Resident #293 was in his room with his door closed and no other interventions were documented to monitor Resident #293 and prevent any further adverse actions. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445387	A. Building B. Wing	09/20/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Parkway Health and Rehabilitation Center	200 South Parkway West Memphis, TN 38109

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 9/16/2021 at 11:08 AM, the Administrator was asked to describe the investigation related to the altercation between Resident #293 and Resident #294 . The Administrator stated, .The night that [Named Resident #293] and [Named Resident #294]'s altercation [occurred], it wasn't witnessed .a resident reported the incident to the nurse .at first he [Resident #294] had no injuries and when the next shift came on, he had started bruising . The Administrator was asked if there were any interventions implemented to protect the other residents in the facility after the altercation occurred. The Administrator stated, .They were separated and [Named Resident #293] was actually transferred to psych [psychiatric facility] [the next day] . During an interview on 9/16/2021 at 1:54 PM, the Regional Director of Clinical Operations (RDCO) confirmed she was the acting Director of Nursing at the time of the resident-to-resident altercation on 7/8/2021. The RDCO was asked if any interventions were implemented to keep Resident #294 from harming the other residents. The RDCO confirmed the residents were on the same hall and the staff took Resident #293 to his room, closed the door so he would not be in contact with other residents, and checked on him to make sure he stayed in his room until he was transferred to the psychiatric facility. The RDCO was asked if any interventions were implemented to protect the other residents. The RDCO stated, .there was no documentation that 1 on 1 supervision or every 15-minute checks were performed . During a telephone interview on 9/17/2021 at 3:01 PM with the Medical Director for the facility. The Medical Director was asked if the other vulnerable residents in the facility should have been protected until Resident #294 was transferred to the psychiatric hospital due to his violent aggressive behavior and if Resident #294 should have been more closely supervised until he was transferred. The Medical Director stated, Yes. During an interview on 9/17/2021 at 3:59 PM, the Administrator was asked when he was notified of the resident-to-resident altercation. The Administrator stated, .it was the next morning . The Administrator was asked what instructions he gave the staff for monitoring Resident #294 until he was transferred to the psychiatric hospital. The Administrator stated, .I didn't . The Administrator was asked considering the severity of Resident #293's injuries and that he was ambulatory, should Resident #293 have been provided increased supervision. The Administrator stated, .I believe monitoring was in order, I trusted the nurses to do that that night. I was disappointed there was nothing done for the resident .I take the heat because I'm the Abuse Coordinator, but I can't report things I don't know .my number is throughout the building, no texting, but to call me .I'm always on call and keep my computer and work phone, and can report from wherever . (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445387	A. Building B. Wing	09/20/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Parkway Health and Rehabilitation Center	200 South Parkway West Memphis, TN 38109

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of a Nurse's Note dated 7/13/2021 at 12:00 AM, revealed [Named Resident #294] wonders [wanders] the building day/night and was last seen by nurse before her lunch break after 8pm [8:00 PM on 7/12/2021]. Upon return from nurses [nurse's] lunch break, the CNA [Certified Nursing Assistant] asked nurse had she saw [seen] resident because she was ready to change him and get him ready for bed. Nurse responded No. After about 30 min [minutes], CNA informed nurse that she still was unable to find resident [Resident #294] and need [needed] help locating resident. Nurse and CNA began looking room to room calling resident's name trying to locate him. After about 15/20 mins [15 to 20 minutes] of looking we called a DR [doctor] Find Me [code for elopement or missing resident] for all employees to help locate resident. Nurse contacted Nurse Manager and informed her that we had been looking for resident for about any [an] hour with no progress .Nurse Manager arrived the search continued. As nurses and Nurse Manager were making their way back up the East Wing towards the nursing station we heard a call for help coming from the housekeeping closet. Resident had got himself locked into the closet and was calling for help out. Administrator informed Nurse Manager on the location of the housekeeping's closet keys so we could unlock door to get resident out. Opening closet door nurse observed resident sitting on floor. We assisted resident out and evaluated. No signs of injury . The facility was unable to provide any documentation that an investigation of this incident was conducted, or documentation of monitoring implemented to ensure Resident #294's safety. Observation of the housekeeping closet on the East hall on 9/15/2021 at 1:14 PM and 1:25 PM, revealed the door was unlocked and had an over-head shelf with 2 (1 quart) containers of Antibacterial Heavy-Duty Cleaner & Odor Counter, 1 (1 quart) of a liquid cream cleanser and 1 (1 quart) bottle of toilet bowl cleanser on the shelf. There was a mop bucket in the closet. Observation of the housekeeping closet on the [NAME] hall on 9/15/2021 at 1:21 PM, revealed the door was unlocked and had an over-head shelf with 1 quart bottle of floor cleaner on the shelf. During an interview on 9/15/2021 at 5:09 PM, the DON was asked who had the responsibility to report the incident to the state and investigate the incident. The DON stated, [Named Administrator] and confirmed the incident had not been reported or investigated. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445387	A. Building B. Wing	09/20/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Parkway Health and Rehabilitation Center	200 South Parkway West Memphis, TN 38109

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 9/16/2021 at 10:49 AM, Licensed Practical Nurse (LPN) #3/Unit Manager was asked to recall the incident when Resident #294 was missing. The LPN stated, .I was actually on vacation, but I was in the area .they [staff] called me on how to move forward .said we've been looking for [Named Resident #294] about 30 minutes. I called the Administrator, and he didn't answer, and I called our acting DON which was the Regional Director of Clinical Operations (RDCO) and she told me she was on the way. I actually found the resident before the DON made it . The LPN was asked where she located the resident. The LPN stated, .he was in the housekeeper's closet .on East [hall] .the door was locked, and I had to locate a key . The LPN was asked if he appeared in distress. The LPN stated, .he was sitting .he was just confused . The LPN was asked if there were any chemicals in the closet. The LPN stated, .I do not recall .I remember looking to see if open containers, but I do not recall . The LPN was asked if the housekeeping closet was routinely left unlocked. The LPN stated, No, it's not supposed to be. The LPN was asked how long she looked for the resident. The LPN stated, .About 10 minutes, if that long .got about 3 rooms in and we reached the closet . The LPN was asked if she completed a statement or incident report. The LPN stated, I did not, I asked the nurse to document the incident . The LPN was asked if she provided any education to the staff after the incident. The LPN stated, .Yes, I was asked that we routinely go and check those doors and make sure the closet was locked .something I did on my way out . The LPN was asked if there was documentation by the staff validating attendance at the in-service. The LPN stated, I did not, it was kind of unofficial. The LPN was asked how she became aware the resident was in the closet. The LPN stated, I could hear him saying open the door or something like that . During an interview on 9/16/2021 at 11:08 AM, the Administrator was asked when he was informed Resident #294 was missing. The Administrator stated, .I got a call maybe if I had to guess, in the 9 o'clock hours, called maybe 10 minutes later the resident had been located . The Administrator was asked if there had been an investigation and were witness statements obtained. The Administrator stated, .I told them to put an incident report in PCC [the electronic medical record] .then we did the QA [Quality Assurance] on our protocol . The Administrator was asked why the incident of the missing person had not been investigated. The Administrator stated, .Because the Unit Manager was there and she had the team to write the note in the system .found the door was actually locked but it wasn't latched, closed, he didn't have the capacity to lock or unlock a door, when he went in it slammed behind him and he couldn't get out . The Administrator was asked when the resident was last seen prior to staff being aware the resident was missing. The Administrator stated, .I talked to [Named LPN #3/Unit Manager] and they [the staff] weren't able to tell her .in my mind great, he wasn't outside, he wasn't hit, nobody brought him to us .they told me he was in the chemical [housekeeping] closet and I know that door has a heavy close . The Administrator was asked if he had reviewed the video camera footage to see how long the resident had been in the closet. The Administrator stated, No. During an interview on 9/16/2021 at 1:54 PM, the RDCO was asked if the incident related to Resident #294 being locked in the housekeeping closet was investigated or reported to the state. The RDCO stated, No. The RDCO was asked if there was any education provided to the staff regarding elopement and wandering residents. The RDCO stated, I don't think so. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445387	A. Building B. Wing	09/20/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Parkway Health and Rehabilitation Center	200 South Parkway West Memphis, TN 38109

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During a telephone interview on 9/17/2021 at 3:01 PM, the physician confirmed he was the Medical Director (MD) for the facility. The Medical Director was asked if he was aware of an incident when a resident was missing. The Medical Director stated, Yes I was, it was brought up [in a QAPI meeting] and it wasn't handled the way it should have been, we talked about that. The Medical Director was asked if he made any recommendations on how it should have been handled. The Medical Director stated, Earlier notification of the Physician or Nurse Practitioner on all, Administrator, DON, try to get people sent out as soon as possible, one with injuries make sure to notify the family right away .I guess the people working that night did not understand that . During an interview on 9/17/2021 at 3:59 PM, the Administrator was asked what involvement he had in the incident when Resident #294 was locked in the housekeeping closet. The Administrator stated, .the staff called to notify me that they had not seen him, I was going to advise them of places to look .I would have never thought of the chemical closet [housekeeping closet] .that door is typically latched, everyone is constantly pulling on that door . The Administrator was asked if after Resident #294 was located was any education regarding the closets being locked provided for the staff. The Administrator stated, .There was not . The Administrator was asked if any staff member conducted an investigation. The Administrator stated, .I can't say it was . The Administrator was asked why the incident of a missing resident was not investigated. The Administrator stated, .I can't report what I don't know .when it was brought to me 5 or 10 minutes later, he was already found so I didn't do that .now that I'm finding out they had been looking for him . The Administrator was asked if an incident of a resident wandering into an unsafe environment unsupervised should be investigated and reported. The Administrator stated, .per our policy, yes. Refer to F-600, F-609 and F-689. The surveyors verified the removal plan by: 1. A Root Cause Analysis was completed on 9/17/2021. The Root Cause Findings identified were the Abuse Coordinator was not notified of the resident-to-resident altercation timely; the Charge Nurse failed to document immediate interventions: and the Charge Nurse failed to document monitoring of residents after a resident-to-resident altercation. The Charge Nurse was suspended for 4 days for failure to notify the Administrator and the Regional Director of Clinical Operations (RDCO) when the incident occurred. The RCA was reviewed by the surveyors 2. On 9/17/2021, the RDCO re-educated the Administrator, Chief Director of Clinical Operations, the Assistant Chief Director of Clinical Operations, the Staff Development Coordinator, and Unit Managers on Abuse & Neglect Prevention, Resident Rights, the Elder Justice Act, the Reporting Guidelines, Storage of Medications, Biologicals & Chemicals, Elopement Behavior Management & Monitoring. The surveyors reviewed the education and interviewed the Administrator, Chief Director of Clinical Operations, the Assistant Chief Director of Clinical Operations, the Staff Development Coordinator, and Unit Managers. 3. On 9/17/2021 & 9/18/2021, 100 % of all current resident and/or resident representatives (if the resident is cognitively impaired) were re-educated on the Abuse & Neglect Prevention Policy, Resident Rights, & the Elder Justice Act. Resident representatives were re-educated on the Abuse & Neglect Prevention Policy, Resident Rights, & the Elder Justice Act. The surveyors interviewed alert and oriented residents and reviewed the medical record for family notification. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445387	A. Building B. Wing	09/20/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Parkway Health and Rehabilitation Center	200 South Parkway West Memphis, TN 38109

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	4. On 9/17/2021 & 9/18/2021, staff were reeducated on Abuse & Neglect Prevention, Resident Rights, the Elder Justice Act, Abuse Reporting Guidelines, Investigation, and Elopement. Employees will not be able to accept a work assignment until the in-services are completed. New hires and employees on leave of absence (LOA) will not be placed on the schedule and/or will not be allowed to return to work until in-services are completed. The surveyors reviewed the in-services and interviewed staff on all shifts. 5. On 9/17/2021 & 9/18/2021, all licensed nurses were educated on Abuse reporting and investigation guidelines, documentation guidelines, behavior management & monitoring, and elopement policies. Employees will not be allowed to accept a work assignment until they have completed the education. The surveyors reviewed the in-services and interviewed nurses on all shifts. 6. The Administrator or CDCO will monitor and audit all reports of alleged abuse and missing residents to assure they are investigated thoroughly. Monitoring will be weekly for 8 weeks then monthly x 3 months. The Administrator will report the findings in the Quality Assurance Performance Improvement (QAPI) meeting monthly for 3 months or until a period of compliance is achieved. The surveyors reviewed the audit log form and interviewed the Administrator and the DON. 7. The Administrator will submit all reports of alleged abuse weekly to the RDCO to review to ensure the process meets regulatory guidelines. The surveyors interviewed the RDCO. The facility's noncompliance of F-610 continues at a scope and severity of D for monitoring the effectiveness of the corrective actions. The facility is required to submit a Plan of Correction.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445387	A. Building B. Wing	09/20/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Parkway Health and Rehabilitation Center	200 South Parkway West Memphis, TN 38109

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38440 Based on video camera footage review, policy review, medical record review, observation, and interview, the facility failed to ensure adequate supervision of cognitively impaired residents that were at risk for wandering and failed to ensure the facility was free of accident hazards for 2 of 10 sampled residents (Resident #293 and #294) reviewed for abuse and wandering. The facility's failure resulted in Immediate Jeopardy when Resident #293 struck Resident #294 which resulted in multiple facial fractures; when Resident #294 wandered from a safe area to an unsafe area without staff knowledge and was found approximately 1 hour later locked in a chemical storage (housekeeping) closet; and when 2 of 2 housekeeping closets [East and [NAME] Hall housekeeping closets] were found unlocked, unattended, and chemicals were stored in the closets. The facility failure to ensure a safe environment that provided supervision for a cognitively impaired resident at risk of wandering and prevent accidents that resulted in actual harm when Resident #293 struck Resident #294 resulting in multiple facial fractures. Immediate Jeopardy (IJ) is a situation in which the provider's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident. The Administrator and Chief Director of Clinical Services (CDCO/Director of Nursing) were notified of the Immediate Jeopardy for F-689 on 9/17/2021 at 2:04 PM, in the Omega Room. The facility was cited Immediate Jeopardy at F-689. The facility was cited F-689 at a scope and severity of J, which is Substandard Quality of Care. The Immediate Jeopardy was effective from 7/8/2021 through 9/19/2021. An acceptable Removal Plan, which removed the immediacy of the jeopardy, was received on 9/19/2021 at 12:16 PM, and was validated onsite by the surveyors on 9/19/2021 and 9/20/2021 through review of root cause analysis, in-services, audits, and staff interviews conducted on all shifts. The findings include: Review of the facility's policy titled, Abuse Prevention, revised on 3/1/2018, revealed .The resident has the right to be free from verbal, sexual, physical and mental abuse, corporal punishment and involuntary seclusion. The resident has the right to be free from mistreatment, neglect and misappropriation of property . It is the responsibility of all staff to provide a safe environment for the residents when abuse, neglect, or exploitation is suspected the Licensed Nurse should .Notify the Director of Nursing and Administrator . Complete an incident report and initiate an immediate investigation to prevent further potential abuse . Interview with the involved resident, if possible and document all responses. If the resident is cognitively impaired, interview the resident several times to compare responses. Interview all witnesses separately . Obtain witness statements .Notify the Ombudsman .Ensure that all alleged violations .are reported immediately, but no later than 2 hours after the allegation is made . (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445387	A. Building B. Wing	09/20/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Parkway Health and Rehabilitation Center	200 South Parkway West Memphis, TN 38109

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the facility's policy titled Elopement Of Resident, dated 9/1/2018, revealed .Should an employee discover that a resident is missing .If not located in 15 minutes .Notify the Administrator and the Director of Nursing Services .Notify the attending physician .Determine the time and location the resident was last seen . Once the Resident is Located .The resident will be assessed by M.D. [Medical Doctor] and documented .The Charge Nurse will complete an Incident Report .The Administrator/Director of Nursing Services will notify the Department of Health per State Regulations .A complete and thorough root-cause analysis of the elopement should be done .reviewed at the next QAPI [Quality Assurance Performance Improvement] meeting . Review of the facility's Unsafe Wandering-Elopement Risk Policy, dated 9/21/2017, revealed Every effort will be made to prevent unsafe wandering .Should an elopement episode occur, an incident report will be completed .If an elopement episode occurs, a monitoring schedule will be implemented to ensure resident safety .The resident's care plan will be updated as to the implementation of the monitoring . Review of the facility's policy titled, Storage Of Medications, Biologicals And Chemicals, dated 10/26/2017, revealed .the facility should ensure that all medications, biologicals and chemicals, including treatment items, are secured in a locked cabinet/cart or locked medication room and locked storage room that is inaccessible by residents and visitors . Review of the medical record, revealed Resident #293 was admitted to the facility on [DATE] with diagnoses of Congestive Heart Failure, Chronic Obstructive Pulmonary Disease, Diabetes, Hypertension, and Schizophrenia. Review of the admission Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #293 had a Brief Interview for Mental Status (BIMS) score of 4 which indicated he was severely cognitively impaired for decision making, wandered on 1-3 days of the 7-day assessment period, and was able to transfer and walk without physical assistance from staff. Review of a Skilled Evaluation for Resident #293 dated 7/8/2021 at 8:40 PM, revealed .Resident does not obey commands .Resident is confused .Mood is pleasant, no unwanted behaviors witnessed . Review of an SBAR (Situation, Assessment, Background, Recommendation) note dated 7/9/2021 at 3:18 AM, revealed, .The Change In Condition/s reported on this CIC [Change In Condition] Evaluation are/were: Behavioral symptoms .Physical aggression . Review of the medical record, revealed Resident #294 was admitted to the facility on [DATE] with diagnoses of Cellulitis, Hypertension, Benign Prostatic Hyperplasia, History of Falling, Vascular Dementia, Osteoarthritis, Age Related Debility, and Protein Calorie Malnutrition. Review of the admission MDS dated [DATE], revealed Resident #294 had a BIMS of 3 which indicated he was severely cognitively impaired for decision making, wandered on 1-3 days of the 7-day assessment period, and required limited assistance with transfer and ambulation. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445387	A. Building B. Wing	09/20/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Parkway Health and Rehabilitation Center	200 South Parkway West Memphis, TN 38109

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the video camera footage provided by the facility, revealed that on 7/8/2021 at 5:38 PM, the doors of the 100-111 hallway were closed and no staff were seen in the hall. Resident #294 ambulated out of his room into the hallway. At 5:39 PM, Resident #294 ambulated toward a room across the hall and was struck on the left side of his face by Resident #293 and the force of the blow knocked him to the floor. Resident #294 fell in the middle of the hallway on his right side. He then sat up and appeared to be trying to get to a standing position when the video ended. Review of a Nurse's Note dated 7/9/2021 at 11:41 AM, revealed Resident #293 and Resident #294 had an altercation in the hallway of the East Station on 7/8/2021. Resident #293 hit Resident #294 with his fist and according to the documentation there were no physical injuries identified at that time. Review of the Nurse's Note dated 7/9/2021 at 4:40 PM. revealed the resident was noted to have a swollen right eye with dark bruising and was sent to the hospital for evaluation. Review of the Nurse's Note dated 7/9/2021 at 11:04 PM, revealed Resident #294 returned to the facility from the acute care hospital on with diagnoses of multiple facial and nasal bone fractures. The facility was unable to provide documentation that Resident #293 had close supervision after the altercation on 7/9/2021 to prevent further aggressive behaviors toward Resident #294 or any other resident in the facility from the time of the incident on 7/8/2021 until he was transferred to a psychiatric facility on 7/9/2021 at 5:30 PM. During an interview on 9/16/2021 at 1:54 PM, the Regional Director of Clinical and Operations (RDCO) confirmed there was no documentation of close supervision for Resident #293 after the incident. During a telephone interview on 9/16/2021 at 9:00 PM, Licensed Practical Nurse (LPN) #1 was asked where Resident #293 was located following the altercation with Resident #294 and the LPN #1 stated the resident was in his room and Resident #293 did not have any increased supervision after the altercation with Resident #294. During an interview on 9/17/2021 at 8:47 AM, LPN #4 was asked how often staff monitored Resident #293 after the incident with Resident #294 to assure he was in his room and LPN #4 stated, .at least every 2 hours but in that situation, I believe I went down there every hour . There was no documentation Resident #293 was monitored closely to assure the resident remained in his room and there were no further incidents or altercations with other residents. Review of the Care Plan for Resident #294 dated 6/24/2021, revealed .has wandering behavior .impaired safety awareness. Resident wanders aimlessly .Maintain wander guard [a mechanical bracelet device that will cause the door to alarm when the resident gets too close to the door] bracelet [initiated 7/13/2021] . Review of the Elopement Evaluation dated 6/28/2021, revealed Resident #294 was a wanderer, had a history of attempting to leave the facility without informing staff, and had verbally expressed the desire to go home. Review of a Skilled Evaluation dated 7/5/2021 at 1:30 PM, revealed, Resident #294 was confused, did not obey commands, had an unsteady gait, wandered, and was exit seeking. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445387	A. Building B. Wing	09/20/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Parkway Health and Rehabilitation Center	200 South Parkway West Memphis, TN 38109

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of a Nurse's Note dated 7/13/2021 at 12:00 AM, revealed Resident #294 wandered throughout the facility during the day and night and was last seen by a nurse on 7/12/2021 after 8:00 PM. Upon return from the lunch break, the Certified Nursing Assistant (CNA) asked the nurse if she had seen Resident #294 as she wanted to prepare him to go to bed for the night. The nurse told her she had not seen the resident.After about 30 minutes the CNA informed the nurse that she still was unable to find the resident and needed assistance locating the resident. The nurse and CNA began looking through all the rooms, calling the resident's name in an attempt to locate the resident. After about 15 to 20 minutes, they decided to call a DR [doctor] Find Me [which is the code for an elopement or missing resident] for all the employees to assist in locating the resident. The nurse contacted the Nurse Manager and informed her that they had been looking for the resident for about an hour with no progress in locating the resident. The Nurse Manager called the Administrator and the DON to inform them while the staff continued to search the facility inside the building and outside the building. As the nursing staff and the Nurse manager were returning to the East Wing toward the nurses station they heard a call for help coming from the housekeeping closet . Resident #294 was locked in the closet and calling for help. The Nurse Manager obtained the keys to the housekeeping closet so they could unlock the door for the resident to come out of the closet. When they opened the door the resident was sitting on the floor of the closet and .no signs of an injury . The facility was unable to provide an incident report, investigation of the incident, or any documentation of monitoring put in place to ensure Resident #294's safety. Observation of the East Hall housekeeping closet on 9/15/2021 at 1:14 PM and 9/15/2021 at 1:25 PM, revealed the door was unlocked, had an over-head shelf with 2 (1 quart) containers of Antibacterial Heavy-Duty Cleaner & Odor Counter, 1 (1 quart) container of a liquid cream cleanser, and 1 (1 quart) bottle of toilet bowl cleaner on the shelf. Observation of the [NAME] hall housekeeping closet on 9/15/2021 at 1:21 PM, revealed, the door was unlocked and had an over-head shelf with 1 (1 quart) bottle of furniture cleaner and 1 (1 quart) bottle of floor cleaner on the shelf. During an interview on 9/15/2021 at 1:56 PM, the Housekeeping Manager confirmed that chemical storage closets should be locked at all times. During an interview on 9/15/2021 at 5:17 PM, LPN #2 was asked how wandering residents are provided the supervision they require. LPN #2 stated, When we figure out, they are [wanderers] we put wander guards on them .as far as monitoring on a day-to-day basis we do the best we can .it's hard to babysit a wanderer . LPN #2 was asked if any doors to rooms or offices were left unlocked where a wandering resident could enter and not be easily observed. LPN #2 stated, .there was an incident when there was a door that was not secured and locked and a resident got into it .I think it was a housekeeping closet and I think the housekeeper left it unlocked or didn't close it all the way .I thought that was like an electrical closet . LPN #2 was asked who located Resident #294 when it was identified he was missing. LPN #2 stated, .It was a group of us walking up the hall .heard him yelling .our Unit Manager was walking past the door and said she thought he was in there .we knocked, and he knocked back . She stated the resident was .sitting in the floor when he was found . LPN #2 stated Resident #294 the staff searched for the resident Probably an hour . and had no injuries when he was located. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445387	A. Building B. Wing	09/20/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Parkway Health and Rehabilitation Center	200 South Parkway West Memphis, TN 38109

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 9/15/2021 at 5:49 PM, the Director of Nursing (DON) was asked about the incident when resident #294 was missing and found locked in the closet. The DON stated, .I received a call saying they could not find the resident and I was headed here .but he was found in a [housekeeping] closet .In a maintenance or storage closet, I think it was maintenance or housekeeping .one of them down on the East Hall . The DON was asked if those closets should be left unlocked. The DON stated, No. During an interview on 9/16/2021 at 10:49 AM, LPN #3/Unit Manager was asked if she recalled the incident when Resident #294 was missing. LPN #3/Unit Manager stated, I was actually on vacation but I was in the area .they [staff] called me on how to move forward, I'm down the street .said we've been looking for [Named Resident #294] about 30 min [minutes] .he was in the housekeeper's closet .on East [Hall] .I could hear him saying open the door or something like that . LPN #3/Unit Manager was asked if the door was locked. LPN #3/Unit Manager stated, It was, I had to locate a key. LPN #3/Unit Manager was asked if that closet was usually unlocked. LPN #3/Unit Manager stated, No, it's supposed to be locked . LPN #3/Unit Manager was unable to recall if chemicals were stored in the closet the night of the incident. During an interview on 9/16/2021 at 1:54 PM, the Regional Director of Clinical Operations (RDCO) was asked what interventions were implemented for Resident #294 after he was found locked in a housekeeping closet on 7/12/2021. The RDCO stated, I wanted him to have a trauma assessment, talked to the doctor . Safety Committee . The RDCO confirmed the incident was not investigated, not reported to the state, and no in-services were provided to staff related to the incident. During an interview on 9/16/2021 at 3:00 PM, the RDCO stated the Safety Committee met on 8/25/2021 related to the incident that occurred on 7/12/2021, 6 weeks after the occurrence. During a telephone interview on 9/17/2021 at 3:01 PM, the Medical Director was asked if he was aware of an incident of a missing resident. The Medical Director stated, Yes I was, it was brought up [in a Quality Assurance meeting] and it wasn't handled the way it should have been, we talked about that. The Medical Director was asked if he made any recommendations on how it should have been handled. The Medical Director stated, Earlier notification of the Physician or Nurse Practitioner on call, Administrator, DON, try to get people sent out as soon as possible .one with injuries make sure to notify the family right away .I guess the people working that night did not understand that . During an interview on 9/17/2021 at 3:59 PM, the Administrator was asked what his involvement was in the incident of the missing resident. The Administrator stated, .the staff called to notify me they had not seen him [Resident #294] .I would have never thought he was in a chemical [housekeeping] closet. The Administrator confirmed that the resident was found before he was able to get to the facility. The Administrator was asked if any in-services or staff education were conducted after the incident to assure the doors of the closet should be locked at all times. The Administrator stated, There was not . Refer to F-600, F-609, F-610, and F-689. The surveyors verified the removal plan by: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445387	A. Building B. Wing	09/20/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Parkway Health and Rehabilitation Center	200 South Parkway West Memphis, TN 38109

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	1. On 9/17/2021, a Root Cause Analysis was completed and found the resident was not provided adequate supervision, the area was made unsafe by failure to properly secure chemical storage and elopement was not reported to proper contacts in a timely manner. The surveyors reviewed the Root Cause Analysis conducted by the RDCO. 2. On 9/17/2021, the RDCO re-educated the Administrator, DON, Assistant CDCO, Staff Development Coordinator, and Unit Managers on Abuse and Neglect Prevention, Resident Rights, the Elder Justice Act, Reporting and Investigation guidelines, Storage of Medications, Biologicals, and Chemicals, Elopement, and Behavior Management and Monitoring. The surveyors reviewed the in-service education provided and interviewed the Administrator, the Staff Development Coordinator, and the DON. 3. On 9/17/2021 and 9/18/2021, 100 percent (%) of all current resident and or resident representatives if the resident was cognitively impaired were re-educated on the Abuse & Neglect Prevention Policy, Resident Rights and the Elder Justice Act. The surveyors interviewed alert and oriented residents and reviewed the medical record for family notification. 4. On 9/17/2021 and 9/18/2021, staff were re-educated on Abuse & Neglect Prevention, Resident's Rights, the Elder Justice Act, the Abuse Reporting and Investigation Guidelines, and Elopement. Employees will not be allowed to work until the in-services are completed. The surveyors reviewed the in-services and interviewed staff on all shifts. 5. The Administrator and the DON will monitor residents identified as at risk for elopement or unsafe wandering in the clinical meeting 5 times per week. The surveyors interviewed the Administrator and the DON. 6. The Administrator, DON, and Director of Maintenance will monitor and audit Storage of Medications, Biologicals and Chemicals specifically to ensure that all appropriate doors are closed and locked. Monitoring will be weekly for 8 weeks then monthly for 3 months. The Administrator will report findings in the QAPI meeting monthly for 3 months or until compliance is achieved. The surveyors reviewed the audit log form and interviewed the Administrator and the Maintenance Director. 7. The RDCO will review all reports of alleged abuse weekly and ensure regulatory guidelines are met. The surveyors interviewed the RDCO. The facility's noncompliance of F-689 continues at a scope and severity of D for monitoring the effectiveness of the corrective actions. The facility is required to submit a Plan of Correction.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445387	A. Building B. Wing	09/20/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Parkway Health and Rehabilitation Center	200 South Parkway West Memphis, TN 38109

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Administer the facility in a manner that enables it to use its resources effectively and efficiently. 37532 Based on policy review, Administrator job description review, Director of Nursing (DON) job description review, and interview, facility Administration failed to administer the facility in a manner that enabled the facility to use its resources effectively and efficiently to attain the highest practicable well-being of residents with wandering behaviors and dementia. Administration failed to provide oversight to monitor and provide a safe resident environment for residents with wandering behaviors and dementia. These failures resulted in Immediate Jeopardy when Resident #293 struck Resident #294 in the face, knocked him to the floor, and Resident #294 sustained numerous facial fractures, and when Resident #294 was missing and was located approximately one hour later in a locked chemical storage (housekeeping) closet. Immediate Jeopardy (IJ) is a situation in which the provider's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident. The Administrator and Chief Director of Operations (CDCO/Director of Nursing) were notified of the Immediate Jeopardy on 9/17/2021 at 6:31 PM, in the Omega Room. The facility was cited Immediate Jeopardy at F-600, F-609, F-610, F-689, F-835, and F-867. The facility was cited Immediate Jeopardy at F-600, F-609, F-610, and F-689 at a scope and severity of J, which is Substandard Quality of Care. The Immediate Jeopardy was effective from 7/8/2021 through 9/19/2021. An acceptable Removal Plan, which removed the immediacy of the jeopardy, was received on 9/19/2021 at 12:16 PM, and was validated onsite by the surveyors on 9/19/2021 and 9/20/2021 through review of review of the root cause analysis, in-services, audits, and staff interviews conducted on all shifts. The findings include: Review of the facility's policy titled, Abuse Prevention Policy, revised 3/1/2018, revealed .The resident has the right to be free from mistreatment, neglect .Neglect means failure to provide goods and services necessary to avoid physical harm, mental anguish or mental illness .When abuse, neglect .is suspected the Licensed Nurse should .Respond to the needs of the resident, and protect them from further abuse .Notify the Director of Nursing and Administrator .Complete an incident report and initiate an immediate investigation to prevent further potential abuse .It is the responsibility of all staff to provide a safe environment for the residents .Examples of ways to protect a resident from harm during an investigation of abuse, neglect .may include .Temporary one on one supervision of a resident .Report and Investigate .Notify the Local Ombudsman office .Ensure that all alleged violations involving abuse, neglect .are reported immediately, but no later than 2 hours after the allegation is made .to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services [APS] . (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445387	A. Building B. Wing	09/20/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Parkway Health and Rehabilitation Center	200 South Parkway West Memphis, TN 38109

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the undated Administrator job description, revealed .The primary purpose of your job position is to direct the day-to-day functions of the facility in accordance with current federal, state, and local standards, guidelines, and regulations that govern nursing facilities to assure that the highest degree of quality care can be provided to our residents at all times .Ensure that all employees, residents, visitors, and the general public follow the facility's established policies and procedures .Make routine inspections of the facility to assure that established policies and procedures are being implemented and followed .Inform the Medical Director of all suspected or known incidents of resident abuse .Review accident/incident reports .Monitor to determine the effectiveness of the facility's risk management program .Ensure that facility procedure manuals .identify safety precautions .that could cause bodily injury or exposure to a hazardous chemical .Ensure that the facility is maintained in a .safe manner for resident comfort and convenience . Review of the undated DON Services job description revealed, .The primary purpose of your job position is to plan, organize, develop and direct the overall operation of our Nursing Service Department in accordance with current federal, state, and local standards, guidelines, and regulations .and as may be directed by the Administrator and the Medical Director, to ensure that the highest degree of quality care is maintained at all times .make daily rounds of the nursing service department to ensure that all nursing service personnel are performing their work assignments in accordance with acceptable nursing standards .Ensure that residents who are unable to call for help are checked frequently .Assist the In-service Director/Educator in developing annual facility in-service training programs .Abuse .Safety .Assist the Safety Officer in developing safety standards for the nursing service department .Ensure that all resident care rooms, treatment areas, etc. [et cetera] are maintained in a .safe .manner .Report and investigate all allegations of resident abuse . During an interview on 9/15/2021 at 5:49 PM, the DON confirmed her employment date was 7/12/2021. The DON was asked about the incident where Resident #294 was missing and was located in the housekeeping closet. The DON stated she was notified they could not locate Resident #294, and she was enroute to the facility when the Administrator notified her Resident #294 had been located in the housekeeping closet on the patient care unit. The DON was asked if the incident should have been reported to the State Survey Agency, the Ombudsman, and Adult Protective Services (APS). The DON stated, I would say if he's missing over a certain amount of time. The DON was asked how long Resident #294 was missing. The DON stated, It appears to be around 30 minutes .[would report] anything over 30 minutes .give them time to look around the facility and outside . During an interview on 9/15/2021 at 6:11 PM, the DON informed the survey team that the incident where Resident #294 had been found locked in a housekeeping closet had not been reported to the State Survey Agency or other appropriate agencies. During an interview on 9/15/2021 at 6:27 PM, the DON informed the survey team an investigation of this incident when Resident #294 had been found locked in a housekeeping closet had not been conducted. The facility was unable to provide an incident report and investigation related to the incident where Resident #294 was found locked in a housekeeping closet. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445387	A. Building B. Wing	09/20/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Parkway Health and Rehabilitation Center	200 South Parkway West Memphis, TN 38109

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 9/16/2021 at 11:08 AM, the Administrator confirmed he did not review the facility camera footage to determine how long Resident #294 was locked in the housekeeping closet. The Administrator confirmed he did not investigate the incident where Resident #294 was locked in the closet. The Administrator confirmed they were unable to identify when Resident #294 was last observed by staff prior to being found locked in the housekeeping closet. During an interview on 9/16/2021 at 1:54 PM, the RDCO confirmed she was aware of the incident when Resident #293 hit Resident #294 in the face. The RDCO was asked what interventions were implemented to protect the other residents from Resident #293, a cognitively impaired resident with aggressive behaviors. The RDCO stated, .took him to his room where the door would be closed, they were rounding on him to make sure he stayed in his room .the next day he was transferred out . The RDCO confirmed the facility did not implement increased supervision of the resident after the incident with Resident #293. The RDCO confirmed the incident was not reported to the State Survey Agency and APS. The RDCO confirmed that education on elopement or locating a missing resident was not provided to staff after Resident #294 was found locked in a housekeeping closet. During an interview on 9/17/2021 at 3:01 PM, the Medical Director confirmed he was aware of the missing resident incident that occurred on 7/12/2021. The Medical Director stated it was discussed in a Quality Assurance meeting and it .wasn't handled the way it should have been, we talked about that. The Medical Director confirmed the Physician or Nurse Practitioner should have received earlier notification. The Medical Director stated, .try to get people sent out as soon as possible, one with injuries make sure to notify the family right away .I guess the people working that night did not understand that . During an interview on 9/17/2021 at 3:59 PM, the Administrator confirmed he was notified the following morning of the incident where Resident #293 struck Resident #294, knocked him to the floor, and caused multiple facial fractures. The Administrator confirmed he did not give staff any instructions on what to do with Resident #293 when he was notified of the incident. The Administrator was asked with the severity of Resident #294's injuries and the fact that Resident #293 was ambulatory, should Resident #293 have been provided closer supervision. The Administrator stated, I believe monitoring was in order .trusted the nurses to .that night I was disappointed, there was nothing done for the resident .I take the heat because I'm the Abuse Coordinator, but I can't report things I don't know . The Administrator confirmed he was notified the staff could not locate Resident #294 on 7/12/2021. The Administrator stated, .Called to notify me that they [staff] had not seen him [Resident #294] .I was going to give them advisement of places to look .would have never thought of the chemical closet [housekeeping closet] .that door is typically latched [locked] . The Administrator confirmed that education to ensure the housekeeping closet was locked was not provided to staff after the incident when Resident #294 was found locked in the closet and an investigation was not conducted on the incident. The Administrator stated, .When it was brought to me .he was already found so I didn't do that [investigation] . The Administrator confirmed he was responsible for reporting incidents to the State Survey Agency. The Administrator was asked if an incident where a resident wandered into an unsafe area unsupervised by staff should be thoroughly investigated and reported. The Administrator stated, Per our policy, yes. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445387	A. Building B. Wing	09/20/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Parkway Health and Rehabilitation Center	200 South Parkway West Memphis, TN 38109

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 9/17/2021 at 5:37 PM, the RDCO confirmed she was the acting DON from 5/25/2021-7/12/2021 and was working the day Resident #293 struck Resident #294 in the face, knocked him to the floor, and he sustained multiple facial fractures. The RDCO confirmed she did not provide guidance to the Administrator and staff regarding the altercation and action that should have been taken after the altercation between Resident #293 and #294. Refer to F-600, F-609, F-610, F-689, and F-867. The surveyors verified the removal plan by: 1. A Root Cause Analysis was completed and found that the Administrator failed to meet standards of his job description as evidenced by a lack of oversight to monitor and provide a safe resident environment, to ensure the facility's resources are utilized effectively to attain and maintain the highest practicable well-being of the residents, and to ensure policies and procedures for Abuse and Neglect, Incident Reporting, Incident Investigation, Accidents, and Quality Assurance and Performance Improvement (QAPI) were followed. The surveyors reviewed the Root Cause Analysis conducted by the RDCO. 2. On 9/17/2021, the Regional Director of Clinical and Operations (RDCO) re-educated the Administrator on his job description including his roles, responsibilities & expectations for ensuring supervision and monitoring of staff to ensure policies and procedures for Abuse and Neglect Prevention, Incident Reporting, Incident Investigation, Accidents, and Quality Assurance Performance Improvement (QAPI) were followed. The surveyors reviewed the in-service education provided and interviewed the Administrator. 3. On September 18, 2021, the RDCO placed the Administrator on a Performance Improvement Plan (PIP) due to the failure to ensure policies and procedures for Abuse and Neglect Prevention, Resident Rights, Elder Justice Act, Reporting and Investigating, Accidents, Elopement, Storage of Medication, Biologicals, and Chemicals, and Behavior Management and Monitoring. The surveyors reviewed the PIP conducted and interviewed the Administrator and RDCO. 4. The RDCO re-educated the Administrator on the QAPI Program policies and procedures on 9/18/2021. The surveyors reviewed the in-service education provided and interviewed the Administrator and RDCO. 5. The Administrator will submit a daily audit log of all resident incidents and accidents to ensure a root cause analysis, an investigation, and appropriate actions have been completed. Any accidents or incidents that meet the requirement of reportable events will be reported within 2 hours, if injury has occurred, and otherwise reported within 24 hours to the appropriate agencies. Findings will be reported to the QAPI committee for review of departmental performance data and communication to ensure residents are protected from abuse and neglect, wandering, and elopement risks. The surveyors reviewed the daily audit log form and interviewed the Administrator. 6. The RDCO will monitor the facility's monthly QAPI committee's internal processes and systems for compliance and follow up related to Abuse and Neglect Prevention, Incident Reporting, Incident Investigation, and Accidents weekly. The surveyors interviewed the RDCO and the Administrator. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445387	A. Building B. Wing	09/20/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Parkway Health and Rehabilitation Center	200 South Parkway West Memphis, TN 38109

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The facility's noncompliance at F-835 continues at a scope and severity of D for monitoring the effectiveness of the corrective actions. The facility is required to submit a Plan of Correction.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445387	A. Building B. Wing	09/20/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Parkway Health and Rehabilitation Center	200 South Parkway West Memphis, TN 38109

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0867 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. 38440 Based on policy review, job description review, document review, medical record review, and interview, the Quality Assurance Performance Improvement (QAPI) committee failed to ensure an effective QAPI program that identified opportunities for improvement related to resident neglect; reported a missing resident incidence to the State Survey Agency and other appropriate agencies; performed tracking and trending of an incident of a missing resident and resident to resident altercation; and failed to implement corrective action or performance improvement activities for a missing resident and resident to resident altercation in order to provide a safe environment for residents, and ensure systems and processes were in place and consistently followed by staff and administration. Failure of the QAPI committee to ensure residents were free from abuse/neglect and ensure an incident of a missing resident was identified, thoroughly investigated, and reported to the appropriate agencies, resulted in Immediate Jeopardy when Resident #294 was missing for over an hour and found in a locked chemical storage (housekeeping) closet and Resident #293 and #294 were involved in a resident-to-resident altercation that resulted in Resident #294 receiving multiple facial fractures. Resident #293 was not sent out of the facility for medical evaluation until the next day. Resident #293 was sent to his room, with the door closed, and told to remain there. The next day he was sent to a psychiatric facility. Neither incident was thoroughly investigated, and interventions were not implemented to avoid it reoccurring. Immediate Jeopardy (IJ) is a situation in which the provider's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident. The Administrator was notified of the Immediate Jeopardy for F-867 on 9/17/2020 at 6:32 PM, in the Omega Room. The facility was cited Immediate Jeopardy at F-600, F-609, F-610, F-689, F 835, and F-867. The facility was cited F-600, F-609, F-610, and F-689 at a scope and severity of J, which is Substandard Quality of Care. The Immediate Jeopardy was effective from 7/8/2021 through 9/19/2021. An acceptable Removal Plan, which removed the immediacy of the Jeopardy was received on 9/19/2021 at 12:16 PM, and was validated onsite by the surveyors on 9/19/2021 and 9/20/2021 through review of the root cause analysis, in-services, audits, and staff interviews conducted on all shifts. The findings include: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445387	A. Building B. Wing	09/20/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Parkway Health and Rehabilitation Center	200 South Parkway West Memphis, TN 38109

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0867 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the facility's policy titled, Quality Assurance Performance Improvement Plan, dated 2015, revealed, Standard of Practice It is the intent of this facility to conduct an on-going quality assurance /performance improvement program designed to systematically monitor and evaluate the quality and appropriateness of resident care, pursue opportunities to improve resident care, resolve identified problems and identify opportunities for improvement. Performance improvement supports the overall goals of the facility and examines both outcomes and processes relevant to these outcomes with the objective of improving the organization's overall performance .The Quality Assurance and Performance Improvement Committee is set up to provide structure and direction for the Performance Improvement Program and Risk Management .The facility will identify areas for Quality Assurance/Performance Improvement monitoring and tools/resources to be used. These monitoring activities should focus on those processes that significantly affect resident outcomes. This ongoing monitoring is used to establish the facility's baseline and the predictability of various outcomes . Criteria for selecting aspects of care for improvement are based on the following .High Volume-aspect of care occurs frequently or affects large number of resident/patient population .High risk-residents/patients are at risk of serious consequences .Problematic-the aspect of care has tended in the past to produce problems for staff, resident and facility .Elopement .Abuse Prohibition . (PIP) Performance Improvement Project Team will be established for the purpose of finding the root cause of the identified areas of concern .The department/committee will document findings, initiate corrective action as directed and present results to the Quality Assurance Performance Improvement Committee . Review of the facility's policy titled, Abuse Prevention Policy, revised 3/1/2018, revealed .The resident has the right to be free from verbal, sexual, physical and mental abuse, corporal punishment and involuntary seclusion. The resident has the right to be free from .neglect .Notify the Director of Nursing and Administrator .Complete an incident report and initiate an immediate investigation to prevent further potential abuse . Obtain witness statements following incident policies .Monitor and document the resident's condition . Document actions taken .in the medical record .It is the responsibility of all staff to provide a safe environment for the residents .Examples of ways to protect a resident .during an investigation of .neglect . Temporary one on one supervision . Review of the facility's policy titled, Elopement Of Resident, dated 9/1/2018, revealed .Should an employee discover that a resident is missing .If not located in 15 minutes .Notify the Administrator and the Director of Nursing Services .Notify the resident's representative .Notify the attending physician .Notify law enforcement officials .Determine the time and location the resident was last seen .Once the Resident is Located .The resident will be assessed by M.D. [medical doctor] and documented .The Charge Nurse will complete an Incident Report .The Administrator/Director of Nursing Services will notify the Department of Health per State Regulations .A complete and thorough root-cause analysis of the elopement should be done .reviewed at the next QAPI meeting . Review of the facility's policy titled undated Residents Rights, revealed .The Resident has the right to be free from verbal, sexual, physical or mental abuse . The facility was unable to provide documentation of in-services or education provided to staff related to an incident of a missing resident that occurred on 7/13/2021. Review of a QAPI document provided by the facility dated 8/25/2021, revealed the committee discussed the incident of the missing resident that occurred on 7/13/2021. This discussion was 6 weeks after the event with the .Root Cause: Left safe area .Increased resident to resident reportables . (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445387	A. Building B. Wing	09/20/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Parkway Health and Rehabilitation Center	200 South Parkway West Memphis, TN 38109

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0867 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the facility's undated Administrator job description, revealed, .The primary purpose of your job position is to direct the day-to-day functions of the facility in accordance with current federal, state, and local standards, guidelines, and regulations that govern nursing facilities to assure that the highest degree of quality care can be provided to our residents at all times .inform the Medical Director of all suspected or known incidents of resident abuse .Review accident/incident reports .Monitor to determine the effectiveness of the facility's risk management program .Ensure that facility procedure manuals .identify safety precautions . that could cause bodily injury or exposure to a hazardous chemical .Ensure that the facility is maintained in a .safe manner for resident comfort and convenience . Review of the facility's undated Director of Nursing job description, revealed, .The primary purpose of your job position is to plan, organize, develop and direct the overall operation of our Nursing Service Department in accordance with current federal, state, and local standards, guidelines, and regulations that govern our facility, and as may be directed by the Administrator and the Medical Director, to ensure that the highest degree of quality care is maintained at all times .Plan, develop organize, implement, evaluate, and direct the nursing service department, as well as its programs and activities, in accordance with current rules, regulations, and guidelines that govern the nursing care facilities .Develop, implement, and maintain an ongoing quality assurance program for the nursing service department .Assist the Quality Assessment & Assurance Committee in developing and implementing appropriate plans of action to correct identified deficiencies .Monitor the facility's QI [Quality Improvement], QM [Quality Management], and survey reports. Assist in developing plans of action to correct potential or identified problem areas .Evaluate and implement recommendations from established committees as they may pertain to nursing services .Assist the In-service Director/Educator in developing annual facility in-service training programs (e.g .Abuse Prevention, Safety, Infection Control, etc.) .Assist the Safety Officer in developing safety standards for the nursing service department .Report and investigate all allegations of resident abuse and/or misappropriation of resident property . Review of the facility's Charge Nurse job description, revealed .The primary purpose of your job description is to provide direct nursing care to the residents, and to supervise the day-to-day nursing activities performed by nursing assistants. Such supervision must be in accordance with current federal, state, and local standards, guidelines, and regulations that govern our facility .to ensure that the highest degree of quality care is maintained at all times .Ensure that all nursing personnel assigned to you comply with the written policies and procedures established by this facility .Complete accident/incident reports as necessary .Report and investigate all allegations of resident abuse and/or misappropriation of resident property . During a telephone interview on 9/17/2021 at 3:01 PM, the Medical Director confirmed that during the Quality Assurance (QA) meeting the resident-to-resident altercation was discussed and the altercation .wasn't handled the way it should have been . The Medical Director confirmed a resident who was being sent to another facility due to the aggressive behaviors should be supervised and the staff should be certain the resident that was injured was treated promptly. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445387	A. Building B. Wing	09/20/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Parkway Health and Rehabilitation Center	200 South Parkway West Memphis, TN 38109

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0867 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 9/17/2021 at 3:59 PM, the Administrator confirmed he was responsible for reporting incidents to the State Survey Agency. He confirmed if a resident wandered into an unsafe environment unsupervised, the incident should be reported and investigated. He confirmed the incident that occurred in July 2021 was not discussed by the QAPI team until August 2021 and the staff did not .handle the incident with Resident #294 appropriately . The Charge Nurse did not notify administration in a timely manner and no education was conducted with the staff. The Administrator confirmed the incidents that occurred in July 2021 were not discussed until the August 2021 QAPI meeting. The Administrator confirmed there had been no in-services or education provided to the staff after this QAPI meeting. The facility could not provide documentation of an Ad Hoc (impromptu) QAPI meeting for the incident on 7/9/2021 of the resident- to- resident altercation or of the missing resident on 7/12/2021. Refer to F-600, F-609, F-610, F-689, and F-835. The facility was previously cited Immediate Jeopardy at F-656, F-678, F-835, and F-867 on 6/12/2020. The surveyors verified the Removal Plan by: 1. On 9/17/2021, a Root Cause Analysis was completed, and it was identified the QAPI Committee failed to implement a systematic approach to ensure staff were trained to identify, investigate, and attempt to identify the root cause for resident-to-resident altercation and missing residents. The Charge Nurse failed to notify the Administrator of the resident-to-resident altercation, and the Administrator failed to notify the State Agency of the missing resident. The surveyors reviewed the Root Cause Analysis conducted by the Regional Director of Clinical Director of Operations (RDCO). 2. On 9/17/2021, a QAPI Ad Hoc meeting was held and led by the Administrator, and was attended by the Medical Director, Clinical Director of Operations (CDCO/Director of Nursing (DON), Assistant Clinical Director of Operations, Unit Managers, Admissions Director and included a Root Cause Analysis, education on Abuse and Neglect Prevention, Resident Rights, the Elder Justice Act, Failure to Investigate, Accidents, Elopement, Storage of Medication, Biologicals, and Chemicals, and Behavior Management and Monitoring. The surveyors reviewed the minutes and interviewed QAPI members. 3. The Administrator and/or CDCO will submit a daily audit log of the monitoring reports of any incidents or accidents, the daily internal communications from electronic clinical dashboard data to ensure any resident incident/accident is consistently identified, investigated, and a root cause is performed with appropriate action. The surveyors reviewed the daily audit log form and interviewed the Administrator. 4. On 9/18/2021, the RDCO re-educated the Interdisciplinary Team (IDT) including the Administrator on the QAPI Program policies and procedures. The surveyors reviewed the in-service education provided and interviewed the Administrator and RDCO. 5. All actions, educations, audits, and monitors will be a part of the QAPI process and reviewed by the QAPI committee. The surveyors interviewed members of the QAPI committee. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445387	A. Building B. Wing	09/20/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Parkway Health and Rehabilitation Center	200 South Parkway West Memphis, TN 38109

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0867 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	6. The QAPI committee will meet monthly or Ad Hoc QAPI meetings will be held after incidents such as resident to resident altercations and missing residents. The surveyors interviewed members of the QAPI committee. The facility's noncompliance at F-867 continues at a scope and severity of D for monitoring the effectiveness of the corrective actions. The facility is required to submit a Plan of Correction.