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	08/30/2022

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 - Some	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** 37533 Based on policy review, job description review, review of facility investigations, review of Grievance Logs, medical record review, observation, and interview, the facility failed to ensure a resident's right to be free from abuse, neglect, and misappropriation for 9 of 13 sampled residents (Resident #5, #14, #25, #29, #30, #50, #549, #550, and #551) reviewed for abuse. The facility's failure to ensure a resident's right to be free from abuse, neglect, and misappropriation resulted in Immediate Jeopardy when the facility failed to identify an incident of resident to resident verbal abuse between Resident #14 and Resident #25, an incident of resident to resident sexual abuse between Resident #14 and Resident #29, an incident of sexual abuse involving Resident #5 and a facility staff member (Certified Nurse Assistant (CNA) #8), incidents of misappropriation of residents' money for Resident #30 and #25 and Resident #50's missing debit card, allegations of neglect for Resident #551, and an allegation of verbal abuse and neglect for Resident #550 by Licensed Practical Nurse (LPN) #6 and LPN #3. The facility failed to ensure a resident was free from neglect when the facility staff neglected to provide adequate supervision for a vulnerable resident (Resident #549) who exited the facility unsupervised and without staff knowledge on 2 separate occasions, 3 days apart. 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 Director of Nursing (DON) were notified of the Immediate Jeopardy during the complaint investigation on 8/12/2022 at 2:50 PM, in the Conference Room. The facility was cited Immediate Jeopardy at F-600. The facility was cited at F-600 at a scope and a severity of J, which is Substandard Quality of Care. The Immediate Jeopardy existed from 3/29/2022 and is ongoing. The findings include: (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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(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 - Some	Review of the facility's Abuse Prevention Policy, reviewed 11/1/2021, revealed .the resident had the right to be free from verbal, sexual, physical, and mental abuse .resident has the right to be free from .neglect and misappropriation of property .The abuse coordinator in the facility is the administrator. Reports of allegations or suspected abuse, neglect, or exploitation .Abuse means the willful infliction of injury .intimidation . depravation .of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being. Abuse may be resident to resident, staff to resident .Verbal abuse .use of oral .language that . includes disparaging and derogatory terms .Sexual abuse includes but not limited to sexual harassment, sexual coercion, or sexual assault .Physical abuse includes hitting, slapping, pinching, kicking .Neglect means failure to provide goods and services necessary to avoid physical harm, mental anguish or mental illness .misappropriation of resident property .misplacement, exploitation, or wrongful temporary or permanent use of a resident's belongings or money .When abuse, neglect or exploitation 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 .obtain witness statements following incident policies; suspend the accused employee .monitor and document the resident's condition, including the response to medical treatment or nursing interventions. Provide initial and follow-up counseling for the resident/s .document actions taken .All facility staff including contractors and volunteers will be educated on abuse, neglect, and exploitation . Review of the facility's policy titled, Resident Grievances, revised 8/22/2017, revealed .resident's right to voice grievances of any nature with the assurance that the facility actively seeks a resolution and keep the resident appropriately apprised of its progress towards resolution .facility is responsible in taking appropriate corrective action . The facility's signed Administrator job description dated 3/1/2022, revealed .Administration .The primary purpose of your job 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 of care can be provided to our residents at all times .you are delegated the administrative authority, responsibility, and accountability necessary for carrying out your assigned duties .Ensure that all employees, residents, visitors and the general public follow the facility's established policies and procedures . Assist the Quality Assurance and Assessment Committee in developing and implementing appropriate plans of action to correct identified quality deficiencies .improvement of services .Ensure that an adequate number of appropriately trained licensed professional and non-licensed personnel are on duty at all times to meet the needs of the residents . The facility's signed Director of Nursing job description dated 7/13/2021, 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 Medial Director, to ensure that the highest degree of quality care is maintained at all times .Review complaints and grievances made by the resident and make a written/oral report to the Administration indicating what action(s) were taken to resolve the complaint or grievance .Report and investigate all allegations of resident abuse and/or misappropriation of resident property . (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of the medical record review, revealed Resident #5 was admitted to the facility on [DATE] with diagnoses of Chronic Obstructive Pulmonary Disease, Congestive Heart Failure, Pulmonary Embolism, Dementia and Epilepsy. Review of an Incident Report dated 7/13/2022, revealed .he [Resident #5] had given a staff member [CNA #8] $187.50 . Review of the quarterly Minimum Data Set (MDS) dated [DATE], revealed a Brief Interview for Mental Status (BIMS) of 12, indicating Resident #5 was moderately impaired cognition. There was no documentation of interviews with Resident #5's roommate or other interviewable residents regarding any unreported allegations of misappropriation by CNA #8. There were no additional staff interviews documented to attempt to identify if the staff had noticed any unreported inappropriate behaviors or statements regarding CNA #8 related to misappropriation. The facility failed to thoroughly investigate the incident of misappropriation to ensure no other residents were victims of misappropriation by CNA #8. Observations from 8/2/2022 through 8/30/2022, revealed Resident #5 was up daily participating in activities and appeared calm. Review of an incident reported by Adult Protective Services (APS) on 8/4/2022, revealed an allegation of sexual relationship involving Resident #5 and CNA #8. During an interview on 8/8/2022 at 4:02 PM, the DON was asked if there had been allegations of a sexual relationship and misappropriation concerning Resident #5. The DON stated, .no reports of a sexual relationship between a staff member and a resident until Adult Protective Services came .to investigate an allegation for [Named Resident #5] .I didn't .start an investigation because APS had already came [come] and you [State Survey Agency] were here . The DON confirmed APS came to interview Resident #5 about a sexual relationship with a CNA #8. During an interview on 8/10/2022 at 4:55 PM, Resident #5 stated, .she [CNA #8] asked me to borrow money to get back and forth to work on .she needed to get an apartment .her purse had gotten stolen .she borrowed money and was supposed to pay me back .then she started dodging me .I took a picture of her with my phone she knew I was taking a picture .she performed oral sex one time here in this room .I didn't report it .it was consensual . During an interview on 8/17/2022 at 11:31 AM, CNA #5 stated, .[Named Resident #5] told me that he thought someone had taken his debit card .I told him I would have to report it .I told [Named Social Worker] .[Named CNA #8] suddenly started staying over on nights and always wanted that hall assigned to her .in May [Named Resident #5] told me he was getting ready to move out into the apartments behind the facility with [Named CNA #8] .he told me he gave her [CNA #8] some money to pay down on an apartment .he told me she gave him oral sex and some of her panties .I told him [Resident #5] he needed to report it when he said he was giving her money for stuff . The facility failed to investigate the incident of alleged sexual misconduct to ensure no other residents were victims of sexual misconduct by CNA #8. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of the medical record, revealed Resident #14 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses of Chronic Kidney Disease, Diabetes, Alcohol Abuse, Anxiety, and Depression. Review of the Progress Note dated 3/29/2022, revealed .resident [#14] has been displaying inappropriate sexual behavior. Resident [#14] grabbing at staff members and descriptively describing their body parts. Resident [#14] stated, 'I'm going [Explicit Word] the [Explicit Word] out of them'. Resident [#14] then stated to niece on phone im [I'm] just [Explicit Word] with them and asking about their [Explicit Word] resident [#14] stated 'I want one of yall [y'all] to hit me so I can slap the shit out of yall [y'all], put me out.' Resident [#14] cursing staff . Review of Resident #14's Progress Note dated 3/30/2022, revealed .On 3/29/22 [2022], the SW [Social Worker] was informed that the resident grabbed the buttocks of a housekeeper and then attempted to grab the activities assistant vaginal [the Activity Assistant's vagina]. The resident was making [NAME] and inappropriate comments and offer the staff money for sex. The SW talked to the resident who then admitted to the behaviors and then attempted the grab the SW. The SW went to the DON's office to report the incident. The resident was asked to come into the DON's office to talk about the incident. The resident admitted what he was accused of and then proceeded to call the staff [Explicit Word] . Review of Progress Note dated 3/31/2022, revealed, .new problem. Staff reports he [Resident #14] has been grossly verbally and physically inappropriate with female staff including threats of physical harm . The facility failed to identify an incident of verbal abuse. Review of the quarterly Minimum Data Set (MDS) dated [DATE], revealed Resident #14 had BIMS score of 6, indicating severely impaired cognition, impaired decision making, and displayed physical and verbal behaviors directed toward others. Review of the quarterly MDS dated [DATE], revealed Resident #14 had a BIMS of 10, indicating moderately impaired cognition. Review of the Care Plan initiated on 6/16/2022, revealed Resident #14 had a behavior problem related to inappropriate sexual behaviors. Observations 8/3/2022 through 8/16/2022 revealed, Resident #14 was up daily, participated in activities, and appeared clean and neat. Observation in the resident's room on 8/17/2022, revealed Resident #14 was in bed and a female staff member was in the room supervising. Review of the medical record, revealed Resident #14 discharged to an acute care hospital on 8/19/2022 due to increased sexual behavior. Review of the medical record, revealed Resident #25 was admitted to the facility on [DATE] with diagnoses of Diabetes, Bipolar Disorder, Depressive Episodes, Hemiplegia and Hemiparesis. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of the quarterly MDS dated [DATE], revealed Resident #25 had a BIMS of 15, which indicated intact cognition. Review of Resident #14's Progress Note dated 6/17/2022, revealed, .On yesterday, the resident [#14] rolled up behind a female resident [Resident #25] and threatened her by stating, I am going to beat your [explicit]. The female resident [Resident #25] notified this SW who then talked to the DON and psych [psychiatric] services . The facility failed identify the incident as verbal abuse and was unable to provide an investigation of this incident to protect to ensure no other residents were victims of abuse from Resident #14. Observations 8/2/2022 through 8/30/2022 revealed Resident #25 was up and participated in activities daily. During an interview on 8/17/2022 at 2:00 PM, the [NAME] President of Clinical Operations confirmed the behaviors would be considered an incident of abuse. During an interview on 8/29/2022 at 9:26 AM, Resident #25 was asked if she was fearful of Resident #14 after he threatened her. Resident #25 stated, .no . During an interview on 8/23/2022 at 8:32 AM, Resident #25 stated, .I had money come up missing in March . I told the [former] Social Worker .I haven't heard anything about the missing money . Review of the 3/2022 Grievance Log, revealed there were no grievances related to Resident #25's missing money. The surveyor informed the DON of Resident #25's report of missing money on 8/27/2022 at 9:50 AM. During an interview on 8/30/2022 at 10:44 AM, the DON stated, .she said the money was misplaced she didn't say it had been taken .just misplaced . During an interview on 8/30/2022 at 10:50 AM, the Administrator stated, .a grievance was filed on 8/22/2022 that the money was misplaced not missing .when I talked to her about it yesterday [8/29/2022] she said the money was missing and she thought someone took it .that's when it became an allegation .doesn't normally take a week to resolve a grievance but she said the money was misplaced . The facility failed to start the investigation until 8/27/2022, 5 days after the Grievance and failed to resolve the allegation of misappropriation until 8/29/2022. Review of the medical record, revealed Resident #29 was admitted to the facility on [DATE] with diagnoses of Iron Deficiency Anemia, Intellectual Disabilities, Psychosis, Anxiety Disorder, and Insomnia. Review of the Resident #14's Psychiatric Nurse Practitioner Progress Note dated 7/14/2022, revealed, . asked to see ahead of scheduled visit due to same problems staff reports he [Resident #14] touched a female resident [Resident #29] inappropriately on her breasts today. This is a pattern of behavior for this resident . (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	The facility failed to identify this incident of sexual abuse. The facility failed to implement interventions to protect residents from further abuse by Resident #14 until 8/17/2022 when Resident #14 was placed on one to one (1:1) supervision. Observations of Resident #29 throughout the onsite visit from 8/2/2022 to 8/17/2022, revealed Resident #29 wandered throughout the facility without a bra, wearing a light-colored t-shirt, and her nipples were noticeable through her clothing. Observations of Resident #29 beginning on 8/18/2022, revealed Resident #29 was wearing a bra and 2 shirts to ensure nipples were not noticeable. Review of the medical record, revealed Resident #30 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses of Osteomyelitis, Paraplegia, Major Depressive Disorder, and Sepsis. Review of the quarterly MDS dated [DATE] revealed Resident #30 was assessed as having a BIMS of 15, indicating he was cognitively intact. Review of the Nurses' Note dated 7/28/2022, revealed Resident #30 reported he had $40.00 missing and his roommate knew where he kept his money. During an interview on 8/12/2022 at 1:02 PM, the DON was asked if she had reported the allegation of missing money for Resident #30. The DON stated, .no, I did not . During an interview on 8/12/2022 at 1:05 PM, the Administrator was asked about the allegation of missing money for Resident #30. The Administrator stated, .this is the first time I've heard about this . The facility was unable to provide an investigation of this incident of misappropriation to ensure no other residents were victims of misappropriation. Review of the medical record revealed, Resident #50 was admitted to the facility on [DATE] with diagnoses of Chronic Obstructive Pulmonary Disease, Malignant Neoplasm of Prostate, and Abnormal Weight Loss. Review of the admission MDS dated [DATE], revealed Resident #50 was assessed as having a BIMS of 14, indicating he was cognitively intact. Observations of during the onsite visit 8/2/2022 through 8/23/2022, revealed Resident #50 was up daily, very cheerful, talkative, and participated in activities. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 8/16/2022 at 3:20 PM, Resident #50 stated, .my debit card came up missing .it was here in my [book] .[Named CNA #8] came in the room to take care of my roommate .I left the room. When I came back the debit card wasn't in my book .I think the CNA took my card .I didn't know to report it .one of the CNAs told me I needed to report it .I went down to the Social Worker's office and left a note on the door . went back down there and the Social Worker was gone .I told [Named Interim Social Worker] that the CNA [Unknown CNA] told me to report it .I cancelled the card myself and ordered a new one .when it didn't show up I contacted [Named Interim Social Worker] to help me get another card . During an interview on 8/17/2022 at 9:39 AM, the Interim Social Worker was asked about the incident related to Resident #50's debit card. The Interim Social Worker stated, .[I] helped him get his debit card he said he misplaced it .he had the card in a [book] when the CNA [CNA #8] left out of the room he said he came back and didn't see his debit card .I suggested putting a hold on the card and requested a statement .I don't have any documentation about this, am I supposed to .I didn't look for the card .I thought it had already been reported since a CNA or a nurse knew about it . Review of the facility's investigation dated 8/19/2022, revealed Resident #50 notified the former Social Worker that his debit card was missing on or around 7/17/2022. The Social Worker notified the Administrator of the missing/alleged theft. The allegations related to misappropriation were not thoroughly investigated or investigated timely. The allegation of misappropriation was not identified until the surveyor questioned the facility about the misappropriation. Review of a closed medical record, revealed Resident #549 was admitted to the facility on [DATE] with diagnoses of Cerebral Infraction, Hypertension, Schizophrenia and Bradycardia. Resident #549 signed Against Medical Advice (AMA) on 7/30/2022 and was discharged . Review of the Brief Interview of Mental Status (BIMS) dated 7/23/2022 revealed Resident #549 was assessed with a score of 14 indicating cognitively intact. Review of the facility's investigation dated 7/27/2022, revealed .Resident last seen by nurse at 7:05 AM .was seen by another resident walking past her window .Speech Therapist saw resident sitting in front of the building [approximately 372 feet from the PUI Hall (Patient Under Investigation hall is an area designated in the facility for residents who have not received the covid vaccination are monitored for a number of days after hospitalization to ensure they do not show Covid symptoms) exit door] and was brought back into the building .30-minute checks .wander guard applied to resident .instructed maintenance to check all exit doors . Review of the Elopement Risk assessment dated [DATE] revealed, Resident #549 was assessed as high risk for elopement. The intervention of a Wander guard bracelet (a monitoring device to alert staff of a resident attempting to exit the facility unattended) was initiated and every 30 minutes safety checks. Review of the Quality Assurance Performance Improvement (QAPI) Root Cause Analysis (RCA) dated 7/27/2022, revealed .[Director of Nursing [DON] not notified of incidences in timely manner .facility failed to complete through investigation of elopement .facility failed to obtain signed and dated written statements from staff with knowledge of the incident . (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of the facility's investigation dated 7/30/2022, revealed .6:40 AM last seeing the resident .Dr. Wander [code for a missing resident] initiated .staff out in cars and on foot .police notified of possible address resident may be located .10:59 AM found resident at [Named] Autobody and Body Panel Shop [approximately 21 miles from facility] .11:30 AM Resident refused to return to facility .signed AMA [Against Medical Advice] papers . Resident #549 was not located for approximately 4 hours. Review of the facility's investigation revealed the facility did not complete a thorough investigation for the incidents of elopement, there were no written statements from nurses providing care to the resident on the previous shifts. During an interview on 8/8/2022 at 12:15 PM, the DON was asked would the wander guard monitor alarm if a resident exited the PUI exit door. The DON stated .no it would not, only the front and back entrance doors are equipped with the wander guard system. The DON was asked if staffing was adjusted to monitor Resident #549 with 30 minutes safety checks and other wandering residents on the East Hall. The DON stated .I did not check the staffing after the elopement . The facility neglected to adequately supervise Resident #549 to prevent incidents of elopement. Review of the medical record, revealed Resident #550 was admitted to the facility on [DATE] with diagnoses of Heart Failure, Diabetes, Schizophrenia, Bipolar Disorder, Major Depressive Disorder, Anxiety Disorder, and Osteoarthritis. Review of the Care Plan dated 8/18/2022, revealed interventions related to anxiety and depression that included monitoring for signs and symptoms of a worsening condition. During an interview on 8/19/2022 at 11:00 AM, Resident #550 stated, .last night the nurse [Named Licensed Practical Nurse (LPN) #3] was rude to me .told me to shut up .I had a bowel movement in the floor because no one would come help me to the bathroom .would not give me my medicine .I've fell 4 times since I've been here . During an interview on 8/20/2022 at 8:30 AM, The [NAME] President of Clinical Operations confirmed the allegation of verbal abuse. During an interview on 8/23/2022 at 3:20 PM, the Administrator confirmed the investigation was not completed and Licensed Practical Nurse (LPN) #3 was allowed return to work on 8/22/2022 before the investigation was completed and coaching was not done with LPN #3 until 8/23/2022. LPN #3 returned to work before the investigation was completed. The Administrator confirmed the staff member should not have been allowed to return to work until a thorough investigation had been completed. Review of a closed medical record, revealed Resident #551 was admitted to the facility on [DATE] with diagnoses of Sepsis, Acute Respiratory Failure, Diabetes, and Chronic Kidney Disease. Review of the admission MDS dated [DATE], revealed Resident #551 was assessed with a BIMS of 15, which indicated intact cognition. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of a Grievance concern dated 6/2/2022, revealed Resident #551 reported the following .after 5pm [5:00 PM] it is like this place shuts down. You can't get a CNA. You stay in bed with feces on you. When it gets later, you get changed but after 12 am [12:00 AM], when you call for assistant [assistance] they say I'm going to let you stay in it until next shift .I experienced this myself. They talk to you like you ain't [aren't] night [right]. I don't know if the people that run this knows but from 5 pm to 6 am [5:00 PM-6:00 AM] it is bad service. They don't answer call lights .It's terrible .Findings employee failed to respond [to the resident's needs and call lights] in timely manner with resident's request stated via resident .explained the routine checks via nursing and ensure .staff would follow protocols. Action taken to correct problem .spoke with CNA about importance of answering call lights timely and to keep resident informed of approx. [approximate] time of arrival .[signed by the DON] . During an interview on 8/23/2022 at 5:58 PM, the DON stated, .when a resident isn't provided care that is neglect the resident's [Resident #551] allegation of neglect .this was not reported and was not investigated because Resident #551 said he just wanted to let someone know about it .I in serviced the staff . The facility did not identify an allegation of neglect and was unable to provide an investigation of the incident to protect other residents from neglect. Refer to F-610 and F-689.

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F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	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** 37533 Based on policy review, job description review, medical record review, and interview, the facility failed to report or timely report incidents of abuse, neglect, and misappropriation to the appropriate agencies for 8 of 13 sampled residents (Resident #5, #14, #25, #29, #30, #50, #72, and #551) reviewed for abuse. The facility's failure to report incidents of abuse to the State Survey Agency resulted in Immediate Jeopardy when the facility failed to report allegations of resident to resident verbal abuse and staff to resident verbal abuse for Resident #14, Resident #25, and Resident #72, an incident of resident to resident sexual abuse between Resident #14 and Resident #29, an incident of sexual abuse and misappropriation for Resident #5 by a facility staff member (Certified Nurse Assistant (CNA) #8), 3 incidents of misappropriation of resident property for Resident #25, Resident #30, and Resident #50, and an allegation of neglect for Resident #551 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 Director of Nursing (DON) were notified of the Immediate Jeopardy for on 8/24/2022 at 7:03 PM, in the Conference Room. The facility was cited Immediate Jeopardy at F-609. The facility was cited at F-609 at a scope and a severity of J, which is Substandard Quality of Care. The Immediate Jeopardy existed from 3/29/2022 and is ongoing. The findings include: Review of the facility's Abuse Prevention Policy, reviewed 11/1/2021, revealed .the resident had the right to be free from verbal, sexual, physical, and mental abuse .resident has the right to be free from .neglect and misappropriation of property .The abuse coordinator in the facility is the administrator. Reports of allegations or suspected abuse, neglect, or exploitation .will be reported immediately to: Facility Abuse Coordinator, Director of Nursing, State Agencies .Abuse means the willful infliction of injury .intimidation .depravation .of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being. Abuse may be resident to resident, staff to resident .Verbal abuse .use of oral .language that .includes disparaging and derogatory terms .Sexual abuse includes but not limited to sexual harassment, sexual coercion, or sexual assault .Physical abuse includes hitting, slapping, pinching, kicking .Neglect means failure to provide goods and services necessary to avoid physical harm, mental anguish or mental illness . misappropriation of resident property .misplacement, exploitation, or wrongful temporary or permanent use of a resident's belongings or money . (continued on next page)

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

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(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 - Some	Review of the facility's signed Administrator job description date of 3/1/2022, revealed .Administration .The primary purpose of your job 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 of 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 . The facility's signed Director of Nursing job description dated 7/13/2021, 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 .Report and investigate all allegations of resident abuse and/or misappropriation of resident property . Review of the medical record, revealed Resident #5 was admitted to the facility on [DATE] with diagnoses of Chronic Obstructive Pulmonary Disease, Congestive Heart Failure, Major Depressive Disorder, Pulmonary Embolism, Dementia, and Epilepsy. Review of the quarterly Minimum Data Set (MDS) dated [DATE], revealed a BIMS of 12, indicating moderately impaired cognition. Review of an Incident Report dated 7/13/2022, revealed .resident stated he had given a staff member [CNA #8] $187.50 . The incident of misappropriation on 7/13/2022 was not reported to the State Survey Agency (SSA) until 7/15/2022, 2 days after the incident occurred. Review of an incident reported by Adult Protective Services (APS) on 8/4/2022, revealed an allegation of sexual relationship involving Resident #5 and CNA #8. During an interview on 8/8/2022 at 4:02 PM, the DON was asked if there had been allegations of a sexual relationship and misappropriation concerning Resident #5. The DON stated, .no reports of a sexual relationship between a staff member and a resident until Adult Protective Services came .to investigate an allegation for [Named Resident #5] .I didn't .start an investigation because APS had already came [come] and you [State Survey Agency] were here . The DON confirmed APS came to interview Resident #5 on 8/5/2022 about a sexual relationship with a CNA #8. The DON was asked if the allegation was reported to the SSA. The DON stated, .no . During an interview on 8/10/2022 at 4:55 PM, Resident #5 stated, .she [CNA #8] asked me to borrow money to get back and forth to work on .she needed to get an apartment .her purse had gotten stolen .she borrowed money and was supposed to pay me back .then she started dodging me .I took a picture of her with my phone she knew I was taking a picture .she performed oral sex one time here in this room .I didn't report it .it was consensual . (continued on next page)

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(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 - Some	During an interview on 8/17/2022 at 11:31 AM, CNA #5 stated, .[Named Resident #5] told me that he thought someone had taken his debit card .I told him I would have to report it .I told [Named Social Worker] .[Named CNA #8] suddenly started staying over on nights and always wanted that hall assigned to her .in May [Named Resident #5] told me he was getting ready to move out into the apartments behind the facility with [Named CNA #8] .he told me he gave her [CNA #8] some money to pay down on an apartment .he told me she gave him oral sex and some of her panties .I told him [Resident #5] he needed to report it when he said he was giving her money for stuff . During an interview on 8/17/2022 at 4:45 PM, the [NAME] President of Clinical Operations was informed of the allegation of sexual abuse involving Resident #5 and CNA #8. The allegation of a sexual relationship was not reported by the facility until 8/19/2022, 14 days after the facility was notified of the allegation. Review of the medical record, revealed Resident #14 was admitted to the facility on [DATE] with readmission on 6/6/2022 with diagnoses of Chronic Kidney Disease, Diabetes, Alcohol Abuse, Anxiety, and Depression. Review of the quarterly Minimum Data Set (MDS) dated [DATE], revealed Resident #14 was assessed as having a Brief Interview for Mental Status (BIMS) score of 6, indicating severely impaired cognition, impaired decision making, and displaying physical and verbal behaviors directed toward others. Review of the quarterly MDS dated [DATE], revealed Resident #14 was assessed with a BIMS of 10, indicating moderately impaired cognition. Review of the Care Plan initiated on 6/16/2022 revealed Resident #14 had a behavior problem related to inappropriate sexual behaviors. Review of the medical record, revealed Resident #25 was admitted to the facility on [DATE] with diagnoses of Diabetes, Bipolar Disorder, Depressive Episodes, Hemiplegia and Hemiparesis. Review of the quarterly MDS dated [DATE], revealed Resident #25 had a BIMS of 15, which indicated intact cognition. Review of Resident #14's Progress Note dated 6/17/2022, revealed, .On yesterday, the resident [#14] rolled up behind a female resident [Resident #25] and threatened her by stating, I am going to beat your [explicit]. The female resident [Resident #25] notified this SW who then talked to the DON and psych [psychiatric] services . During an interview on 8/17/2022 at 2:00 PM, the [NAME] President of Clinical Operations confirmed this was an incident of abuse and it was not reported to the SSA until 8/19/2022. During an interview on 8/23/2022 at 8:32 AM, Resident #25 stated, .I had money come up missing in March . The surveyor notified the DON of Resident #25's misappropriation allegation on 8/27/2022 at 9:50 AM. (continued on next page)

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F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 8/30/2022 at 10:44 AM, the DON stated, .she [Resident #25] said the money was misplaced she didn't say it had been taken .just misplaced . During an interview on 8/30/2022 at 10:50 AM, the Administrator stated, .a grievance was filed on 8/22/2022 that the money was misplaced not missing .when I talked to her about it yesterday [8/29/2022] she said the money was missing and she thought someone took it .that's when it became an allegation .doesn't normally take a week to resolve a grievance but she said the money was misplaced .I reported it on 8/29/2022 . The facility did not report the allegation of misappropriation to the SSA until 8/29/2022, 2 days after the SSA notified the facility of the alleged misappropriation. Review of the medical record revealed Resident #29 was admitted to the facility on [DATE] with diagnoses of Iron Deficiency Anemia, Intellectual Disabilities, Psychosis, Anxiety Disorder, and Insomnia. Review of the quarterly MDS dated [DATE], revealed Resident #29 was assessed as having a BIMS of 2, indicating severe cognitive impairment. Review of the Resident #14's Psychiatric Nurse Practitioner Progress Note dated 7/14/2022, revealed, . asked to see ahead of scheduled visit due to same problems staff reports he [Resident #14] touched a female resident [Resident #29] inappropriately on her breasts today. This is a pattern of behavior for this resident . The incident of sexual abuse involving Resident #14 and Resident #29 was not reported to the SSA until 8/19/2022. During an interview on 8/18/2022 at 9:49 AM, the [NAME] President of Clinical Operations stated, .these incidents are abuse, should have been reported .not reported timely .the policies and procedures were not followed . Review of the medical record, revealed Resident #30 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses of Osteomyelitis, Paraplegia, Major Depressive Disorder, and Sepsis. Review of the quarterly MDS dated [DATE], revealed Resident #30 was assessed as having a BIMS of 15, indicating he was cognitively intact. Review of the Nurses' Note dated 7/28/2022, revealed Resident #30 reported he had $40.00 missing and his roommate knew where he kept his money. During an interview on 8/12/2022 at 1:02 PM, the DON was asked if the allegation of misappropriation was reported to the SSA. The DON stated, .no, I did not . During an interview on 8/12/2022 at 1:05 PM, the Administrator was asked about the allegation of misappropriation for Resident #30. The Administrator stated, .this is the first time I've heard about this . (continued on next page)

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F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of the medical record, revealed Resident #50 was admitted to the facility on [DATE] with diagnoses of Chronic Obstructive Pulmonary Disease, Malignant Neoplasm of Prostate, and Abnormal Weight Loss. Review of the admission MDS dated [DATE], revealed Resident #50 was assessed as having a BIMS of 14, indicating he was cognitively intact. During an interview on 8/16/2022 at 3:20 PM, Resident #50 stated, .my debit card came up missing .it was here in my [book] .[Named CNA #8] came in the room to take care of my roommate .I left the room. When I came back the debit card wasn't in my book .I think the CNA took my card .I didn't know to report it .one of the CNAs told me I needed to report it .I went down to the Social Worker's office and left a note on the door . went back down there and the Social Worker was gone .I told [Named Interim Social Worker] that the CNA [Unknown CNA] told me to report it .I cancelled the card myself and ordered a new one .when it didn't show up I contacted [Named Interim Social Worker] to help me get another card . During an interview on 8/17/2022 at 9:39 AM, the Interim Social Worker was asked about the incident related to Resident #50's debit card. The Interim Social Worker stated, .[I] helped him get his debit card he said he misplaced it .he had the card in a [book] when the CNA [CNA#8] left out of the room he said he came back and didn't see his debit card .I suggested putting a hold on the card and requested a statement .I don't have any documentation about this, am I supposed to .I didn't look for the card .I thought it had already been reported since a CNA or a nurse knew about it .he said he had told the [former Social Worker] . The allegation of misappropriation was not reported to the SSA until 8/19/2022. Review of a closed medical record, revealed Resident #72 was admitted to the facility on [DATE] with diagnoses of Rhabdomyolysis, Schizoaffective Disorder, Cognitive Communication Deficit, Dysphagia, and Malignant Neoplasm of Prostate. Review of the Nurses' Note dated 6/10/2022 at 7:15 AM, revealed .Assigned nurse at cart 1 restocking. dietary personnel on floor at this time entering kitchen bring coffee for am breakfast. Resident [Resident #72] up in w/c [wheelchair] sitting several steps away from kitchen stated, 'To [to] dietary personnel to give a cup of coffee.' dietary staff attempted to explain she can't served [serve]. Nurse at side attempted to explains [explain that] dietary personnel unable to give coffee resident nursing staffs [staff] will serve [coffee to the resident]. Resident yelling at nurse with increase [increased] agitation and cursing. yelling in loud tones stating nurse a [NAME] U [you] hating on me about the coffee. you don't want nobody to like me you a street nigger and I will beat a [Explicit Words]. Stay out of my business. I was talking to that lady not you. Nurse voiced understanding and stepped away resident continue to approach with continue cursing's [continued cursing] Resident calming down some. Will continue to monitor . Review of the quarterly MDS dated [DATE], revealed Resident #72 had a BIMS score of 10, indicating moderately impaired cognition and verbal behavioral symptoms directed toward others. During an interview on 8/11/2022 at 11:35 AM, the Environmental Services Account Manager stated, .one of my employees has [had] witnessed verbal abuse .[Housekeeper #1] told me they heard a staff member threaten a resident in the Dining Room . (continued on next page)

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F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 8/11/2022 at 2:12 PM, the Housekeeper #1 stated, .I heard the [Named former Activities Assistant] threaten to slap the shit out of [Named Resident #72] in the Dining Room about 2-3 weeks ago . During a telephone interview on 8/15/2022 at 5:27 PM, the former Activity Assistant stated, .I had reported the resident's abusive statements and treatment to the Administration, they didn't do anything .yes I told him I was going to slap the shit out of him .he had run over me, threw an apron at me, knocked a box out of my hand and shoved a table at me . The allegation of verbal abuse was reported to the SSA on 6/20/2022, 3 days after the incident occurred on 6/17/2022. Review of a closed medical record, revealed Resident #551 was admitted to the facility on [DATE] with diagnoses of Sepsis, Acute Respiratory Failure, Diabetes, and Chronic Kidney Disease. Review of the MDS dated [DATE], revealed Resident #551 was assessed with a BIMS of 15. Resident #551 was discharged home on 6/6/2022. Review of a Grievance concern dated 6/2/2022, revealed Resident #551 reported the following .after 5pm [5:00 PM] it is like this place shuts down. You can't get a CNA. You stay in bed with feces on you. When it gets later, you get changed but after 12 am [12:00 AM], when you call for assistant [assistance] they say I'm going to let you stay in it until next shift .I experienced this myself. They talk to you like you ain't [aren't] night [right]. I don't know if the people that run this knows but from 5 pm to 6 am [5:00 PM-6:00 AM] it is bad service. They don't answer call lights .It's terrible .Findings employee failed to respond [to the resident's needs and call lights] in timely manner with resident's request stated via resident .explained the routine checks via nursing and ensure .staff would follow protocols. Action taken to correct problem .spoke with CNA about importance of answering call lights timely and to keep resident informed of approx. [approximate] time of arrival .[signed by the DON] . During an interview on 8/23/2022 at 5:58 PM, the DON was asked if not providing care or answering call lights would be considered neglect. The DON stated, yes .when a resident isn't provided care that is neglect The DON was asked about Resident #551's allegation of neglect. The DON stated, .this was not reported and was not investigated because he said just wanted to let someone know about it . The facility did not report the allegation of neglect to the SSA.

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(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 - Some	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37533 Based on policy review, review of the Director of Nursing (DON) job description, Grievance logs and report review, and facility investigation review, medical record review, and interview, the facility failed to complete a thorough investigation related to abuse for 9 of 13 sampled residents (Resident #5, #14, #25, #29, #30, #50, #72, #549, and #551) reviewed for abuse and neglect. The facility's failure to thoroughly investigate incidents and/or allegations of abuse resulted in Immediate Jeopardy when the facility failed to thoroughly investigate incidents of resident to resident verbal abuse and staff to resident verbal abuse for Resident #14, Resident #25, Resident #50, and Resident #72, failed to thoroughly investigate an incident of resident to resident sexual abuse between Resident #14 and Resident #29, failed to thoroughly investigate an incident of sexual abuse and misappropriation for Resident #5 by a facility staff member (Certified Nurse Assistant (CNA) #8), failed to thoroughly investigate 3 incidents of misappropriation of resident property for Resident #30, #25, and #50, failed to thoroughly investigate incidents of elopement when Resident #549 exited the building without staff knowledge or supervision on 2 occasions, 3 days apart, and failed to thoroughly investigate an allegation of neglect for Resident #551. 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 Director of Nursing (DON) were notified of the Immediate Jeopardy for F-610 during the complaint investigation on 8/12/2022 at 2:50 PM, in the Omega Room. The facility was cited Immediate Jeopardy at F-610. The facility was cited at F-610 at a scope and a severity of K, which is Substandard Quality of Care. The Immediate Jeopardy existed from 3/29/2022 and is ongoing. The findings include: (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of the facility's Abuse Prevention Policy, reviewed 11/1/2021, revealed .the resident had the right to be free from verbal, sexual, physical, and mental abuse .resident has the right to be free from .neglect and misappropriation of property .The abuse coordinator in the facility is the administrator. Reports of allegations or suspected abuse, neglect, or exploitation .will be reported immediately to: Facility Abuse Coordinator, Director of Nursing, State Agencies .Abuse means the willful infliction of injury .intimidation .depravation .of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being. Abuse may be resident to resident, staff to resident .Verbal abuse .use of oral .language that .includes disparaging and derogatory terms .Sexual abuse includes but not limited to sexual harassment, sexual coercion, or sexual assault .Physical abuse includes hitting, slapping, pinching, kicking .Neglect means failure to provide goods and services necessary to avoid physical harm, mental anguish or mental illness . misappropriation of resident property .misplacement, exploitation, or wrongful temporary or permanent use of a resident's belongings or money .When abuse, neglect or exploitation 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. Notify the attending physician, resident's family/legal representative and Medical Director .obtain witness statements following incident policies; suspend the accused employee .monitor and document the resident's condition, including the response to medical treatment or nursing interventions. Provide initial and follow-up counseling for the resident/s .document actions taken .All facility staff including contractors and volunteers will be educated on abuse, neglect, and exploitation .Investigations of alleged Abuse, Neglect and Exploitation .must start immediately .When suspicion or reports of abuse, neglect or exploitation occur, an investigation is immediately warranted .Components of the investigation may include: Interview with the involved resident, if possible, and document all responses. If resident is cognitively impaired, interview the resident several times to compare responses. Interview all witnesses separately. Include roommates, residents in adjoining rooms, staff members in the area and visitors in the area . Document the entire investigation chronologically .Administrator will review investigational findings . Administrator will review outcome in monthly continuous quality improvement meeting . Review of the facility's signed Director of Nursing job description dated 7/13/2021, 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 Medial Director, to ensure that the highest degree of quality care is maintained at all times .Review complaints and grievances made by the resident and make a written/oral report to the Administration indicating what action(s) were taken to resolve the complaint or grievance .Report and investigate all allegations of resident abuse and/or misappropriation of resident property . Review of the medical record, revealed Resident #5 was admitted to the facility on [DATE] with diagnoses of Hemiplegia and Hemiparesis, Congestive Heart Failure, Depression, Dementia, and Epilepsy. Review of the quarterly Minimum Data Set (MDS) dated [DATE], revealed a Brief Interview for Mental Status (BIMS) of 12, indicating moderately impaired cognition. (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of a facility investigation revealed the facility received an allegation of misappropriation of Resident #5's money on 7/13/2022. The facility's investigation included an Alleged Abuse Incident Report dated 7/13/2022 at 2:29 PM indicating Resident #5 stated he had given a staff member $187.50, an employee warning notice dated 7/14/2022 for CNA #8, and a printout of the Resident Account Statement from 3/2022 to 7/13/2022. There was no documentation of interviews with Resident #5's roommate or other interviewable residents regarding any unreported allegations of misappropriation by CNA #8. There were no additional staff interviews documented to attempt to identify if the staff had noticed any unreported inappropriate behaviors or statements regarding CNA #8 related to misappropriation. The allegation of misappropriation was not thoroughly investigated. During an interview on 8/8/2022 at 4:02 PM, the DON was asked if there had been allegations of a sexual relationship and misappropriation concerning Resident #5. The DON stated, .no reports of a sexual relationship between a staff member and a resident until Adult Protective Services [APS] came .to investigate an allegation for [Named Resident #5] .I didn't report it or start an investigation because APS had already came [come] and you [State Survey Agency] were here . During an interview on 8/10/2022 at 4:55 PM, Resident #5 stated, .she [CNA #8] asked me to borrow money to get back and forth to work on .she needed to get an apartment .her purse had gotten stolen .she borrowed money and was supposed to pay me back .then she started dodging me .I took a picture of her with my phone she knew I was taking a picture .she performed oral sex one time here in this room .I didn't report it .it was consensual . During an interview on 8/17/2022 at 11:31 AM, CNA #5 stated, .[Named Resident #5] told me that he thought someone had taken his debit card .I told him I would have to report it .I told [Named Social Worker] .[Named CNA #8] suddenly started staying over on nights and always wanted that hall assigned to her .in May [Named Resident #5] told me he was getting ready to move out into the apartments behind the facility with [Named CNA #8] .he told me he gave her [CNA #8] some money to pay down on an apartment .he told me she gave him oral sex and some of her panties .I told him [Resident #5] he needed to report it when he said he was giving her money for stuff . The facility was unable to provide documentation that the allegation of sexual abuse and misappropriation by a staff member was investigated and investigated timely. Review of the medical record, revealed Resident #14 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses of Chronic Kidney Disease, Diabetes, Alcohol Abuse, Anxiety and Depression. Review of the Progress Note dated 3/29/2022, revealed .resident [#14] has been displaying inappropriate sexual behavior. Resident [#14] grabbing at staff members and descriptively describing their body parts. Resident [#14] stated, 'I'm going [Explicit Word] the [Explicit Word] out of them'. Resident [#14] then stated to niece on phone im [I'm] just [Explicit Word] with them and asking about their [Explicit Word] resident [#14] stated 'I want one of yall [ya'll] to hit me so I can slap the shit out of yall [ya'll], put me out.' Resident [#14] cursing staff . (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of Resident #14's Progress Note dated 3/30/2022, revealed .On 3/29/22 [2022], the SW [Social Worker] was informed that the resident grabbed the buttocks of a housekeeper and then attempted to grab the activities assistant vaginal [the Activity Assistant's vagina]. The resident was making [NAME] and inappropriate comments and offer the staff money for sex. The SW talked to the resident who then admitted to the behaviors and then attempted the grab the SW. The SW went to the DON's office to report the incident. The resident was asked to come into the DON's office to talk about the incident. The resident admitted what he was accused of and then proceeded to call the staff [Explicit Word] . Review of Progress Note dated 3/31/2022, revealed, .new problem. Staff reports he [Resident #14] has been grossly verbally and physically inappropriate with female staff including threats of physical harm . Review of the quarterly MDS dated [DATE], revealed Resident #14 was assessed as having a BIMS score of 6, indicating severely impaired cognition, impaired decision making, and displaying physical and verbal behaviors directed toward others. Review of the quarterly MDS dated [DATE], revealed Resident #14 was assessed with a BIMS of 10, indicating moderately impaired cognition. Review of the Care Plan initiated on 6/16/2022, revealed Resident #14 was assessed for behavior problem related to inappropriate sexual behaviors. Medical record review revealed Resident #25 was admitted to the facility on [DATE] with diagnoses of Diabetes, Bipolar Disorder, Depressive Episodes, Hemiplegia and Hemiparesis. Review of the quarterly MDS dated [DATE], revealed Resident #25 was assessed with a BIMS of 15, which indicated intact cognition. Review of the Resident #14's Progress Note dated 6/17/2022, revealed .On yesterday, the resident rolled up behind a female resident and threatened her by stating, 'I am going to beat your [Explicit Word].' The female resident [Resident #25] notified this SW who then talked to the DON and psych [Psychiatric] services . The facility was unable to provide an investigation of this incident. Review of the medical record, revealed Resident #29 was admitted to the facility on [DATE] with diagnoses of Iron Deficiency Anemia, Intellectual Disabilities, Psychosis, Anxiety Disorder, and Insomnia. Review of the quarterly MDS dated [DATE], revealed Resident #29 was assessed as having a BIMS of 2, indicating severe cognitive impairment. Review of a Physician's Progress Note for Resident #14 dated 7/14/2022, revealed .increased sexual behaviors .[Resident #14] feeling on resident's [Resident #29] breast . (continued on next page)

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Parkway Health and Rehabilitation Center	200 South Parkway West Memphis, TN 38109

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of the Psychiatric Nurse Practitioner Progress Note dated 7/14/2022, revealed .asked to see ahead of scheduled visit due to same problems staff reports he [Resident #14] touched a female resident [Resident #29] inappropriate on her breasts today. This is a pattern of behavior for this resident .says the female resident invited him to touch her. Pointed out that she has little verbal and is not capable of that .continued to deny responsibility .more angry outbursts are occurring .continued instances of impulsive behaviors .Non pharm [pharmacological] interventions have been ineffective . The facility was unable to provide an investigation of this incident. During an interview on 8/18/2022 at 9:49 AM, the [NAME] President (VP) of Clinical Operations stated, . these incidents [of abuse] .were not investigated .the policies and procedures we have in place were not followed . During an interview on 8/23/2022 at 8:32 AM , Resident #25 stated, .I had money come up missing in March . Review of the 3/2022 Grievance Log, revealed there were no grievances related to Resident #25's missing money. Review of a Grievance dated 8/22/2022, revealed, .date of the incident unknown .resident says she had $20 misplaced when she was in room [named number] Resident unsure of what happened with the money . Resident admitted to room [named number] 3/2/22 [2022]. Resident says she told a staff member that no longer is employed @ [at] the facility. UM [Unit Manager] has no knowledge of missing money. Residents in the area denies having item missing .unable to validate the resident's accusation of misplaced money .The date complainant notified of the investigation results 8/29/2022 notified by the Administrator . The surveyor notified the DON of Resident #25's concern related to missing money on 8/27/2022 at 9:54 AM. During an interview on 8/30/2022 at 10:44 AM, the DON stated, .she said the money was misplaced she didn't say it had been taken .just misplaced . During an interview on 8/30/2022 at 10:50 AM, the Administrator stated, .a grievance was filed on 8/22/2022 that the money was misplaced not missing .when I talked to her about it yesterday [8/29/2022] she said the money was missing and she thought someone took it .that's when it became an allegation .doesn't normally take a week to resolve a grievance but she said the money was misplaced . The facility failed to start the investigation until 8/27/2022, 5 days after the Grievance. Review of the medical record, revealed Resident #30 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses of Osteomyelitis, Paraplegia, Major Depressive Disorder, and Sepsis. Review of the quarterly MDS dated [DATE], revealed Resident #30 was assessed as having a BIMS of 15, indicating he was cognitively intact. (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of the Nurses' Note dated 7/28/2022, revealed Resident #30 reported he had $40.00 missing and his roommate knew where he kept his money. During an interview on 8/12/2022 at 1:02 PM, the DON was asked about a Grievance by Resident #30. The DON stated, .I talked to the resident [Resident #30] .we could not prove he had the $40.00 . During an interview on 8/12/2022 at 1:05 PM, the Administrator was asked about the Grievance by Resident #30. The Administrator stated, .this is the first time I've heard about this . The facility was unable to provide an investigation of this incident. Review of the medical record, revealed Resident #50 was admitted to the facility on [DATE] with diagnoses of Chronic Obstructive Pulmonary Disease, Malignant Neoplasm of Prostate and Abnormal Weight Loss. Review of the admission MDS dated [DATE], revealed Resident #50 was assessed with a BIMS of 14, indicating he was cognitively intact. During an interview on 8/16/2022 at 3:20 PM, Resident #50 stated, .my debit card came up missing .it was here in my [book] .[Named CNA #8] came in the room to take care of my roommate .I left the room. When I came back the debit card wasn't in my book .I think the CNA took my card .I didn't know to report it .one of the CNAs told me I needed to report it .I went down to the Social Worker's office and left a note on the door . went back down there and the Social Worker was gone .I told [Named Interim Social Worker] that the CNA [Unknown CNA] told me to report it .I cancelled the card myself and ordered a new one .when it didn't show up I contacted [Named Interim Social Worker] to help me get another card . During an interview on 8/17/2022 at 9:39 AM, the Interim Social Worker was asked about the incident related to Resident #50's debit card. The Interim Social Worker stated, .[I] helped him get his debit card he said he misplaced it .he had the card in a [book] when the CNA [CNA #8] left out of the room he said he came back and didn't see his debit card .I suggested putting a hold on the card and requested a statement .I don't have any documentation about this, am I supposed to .I didn't look for the card .I thought it had already been reported since a CNA or a nurse knew about it . Review of the facility's investigation dated 8/19/2022, revealed Resident #50 notified the former Social Worker that his debit card was missing on or around 7/17/2022. The Social Worker notified the Administrator of the missing/alleged theft. The allegations related to misappropriation were not thoroughly investigated or investigated timely. Review of a closed medical record, revealed Resident #72 was admitted to the facility on [DATE] with diagnoses of Rhabdomyolysis, Schizoaffective Disorder, Cognitive Communication Deficit and Malignant Neoplasm of Prostate. (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of the Nurses' Note dated 6/10/2022 at 7:15 AM, revealed .Assigned nurse at cart 1 restocking. dietary personnel on floor at this time entering kitchen bring coffee for am breakfast. Resident [Resident #72] up in w/c [wheelchair] sitting several steps away from kitchen stated, 'To [to] dietary personnel to give a cup of coffee.' dietary staff attempted to explain she can't served [serve]. Nurse at side attempted to explains [explain that] dietary personnel unable to give coffee resident nursing staffs [staff] will serve [coffee to the resident]. Resident yelling at nurse with increase [increased] agitation and cursing. yelling in loud tones stating nurse a [NAME] U [you] hating on me about the coffee. you don't want nobody to like me you a street nigger and I will beat a [Explicit Words]. Stay out of my business. I was talking to that lady not you. Nurse voiced understanding and stepped away resident continue to approach with continue cursing's [continued cursing] Resident calming down some. Will continue to monitor . Review of the quarterly MDS dated [DATE], revealed Resident #72 had a BIMS score of 10, indicating moderately impaired cognition and verbal behavioral symptoms directed toward others. During an interview on 8/11/2022 at 11:35 AM, the Environmental Services Account Manager stated, .one of my employees has [had] witnessed verbal abuse .[Housekeeper #1] told me they heard a staff member threaten a resident in the Dining Room . During an interview on 8/11/2022 at 2:12 PM, Housekeeper #1 stated, .I heard the [Named former Activities Assistant] threaten to slap the shit out of [Named Resident #72] in the Dining Room about 2-3 weeks ago .I wasn't interviewed about it or asked to write a statement . During an interview on 8/12/2022 at 1:54 PM, the Administrator stated, .I interviewed dietary and environmental no one said they heard anything .I don't have documented who specifically I interviewed and what they said . During a telephone interview on 8/15/2022 at 5:27 PM, the former Activities Assistant stated, .I had reported the resident's abusive statements and treatment to the Administration, they didn't do anything .yes I told him I was going to slap the shit out of him .he had run over me, threw an apron at me, knocked a box out of my hand and shoved a table at me . The facility's investigation did not include the names of staff interviewed, there were no interviews with other residents or other staff members to ensure there were no other incidents related to the former Activity Assistant's threat of physical violence. Review of the medical record, revealed Resident #549 was admitted to the facility on [DATE] with diagnoses of Cerebral Infraction, Hypertension, Schizophrenia and Bradycardia. Review of the Clinical Admission Evaluation dated 7/22/2022, revealed Resident #549 had disorganized thinking, walked with an unsteady gait and poor balance, and wandered at night. Review of the BIMS assessment dated [DATE], revealed Resident #549 had a score of 14 indicating he was cognitively intact. (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of the facility's investigation dated 7/27/2022, revealed .Resident last seen by nurse at 7:05 AM .was seen by another resident walking past her window .Speech Therapist saw resident sitting in front of the building [approximately 372 feet from the PUI Hall (Patient Under Investigation hall is where patients who have not been vaccinated for Covid are observed for covid symptoms for a number of days after being hospitalized) exit door] and was brought back into the building .30-minute checks .wander guard applied to resident .instructed maintenance to check all exit doors . Review of the Elopement Risk assessment dated [DATE] revealed, Resident #549 was assessed as high risk for elopement. The intervention of a Wander guard bracelet (a monitoring device to alert staff of a resident attempting to exit the facility unattended) was initiated and every 30 minutes safety checks. Review of the Quality Assurance Performance Improvement (QAPI) Root Cause Analysis (RCA) dated 7/27/2022, revealed .[Director of Nursing [DON] not notified of incidences in timely manner .facility failed to complete through investigation of elopement .facility failed to obtain signed and dated written statements from staff with knowledge of the incident . Review of the facility's investigation dated 7/30/2022, revealed .6:40 AM last seeing the resident .Dr. Wander [code for a missing resident] initiated .staff out in cars and on foot .police notified of possible address resident may be located .10:59 AM found resident at [Named] Autobody and Body Panel Shop [approximately 21 miles from facility] .11:30 AM Resident refused to return to facility .signed AMA [Against Medical Advice] papers . Resident #549 was not located for approximately 4 hours. Review of the facility's investigation revealed the facility did not complete a thorough investigation for the incidents of elopement, there were no written statements from nurses providing care to the resident on the previous shifts. Review of the medical record, revealed Resident #551 was admitted to the facility on [DATE] with diagnoses of Sepsis, Acute Respiratory Failure, Diabetes, and Chronic Kidney Disease. Review of the admission MDS dated [DATE], revealed Resident #551 was assessed as having a BIMS of 15, indicating he was cognitively intact. Review of a Grievance concern dated 6/2/2022, revealed Resident #551 reported the following .after 5pm [5:00 PM] it is like this place shuts down. You can't get a CNA. You stay in bed with feces on you. When it gets later, you get changed but after 12 am [12:00 AM], when you call for assistant [assistance] they say I'm going to let you stay in it until next shift .I experienced this myself. They talk to you like you ain't [aren't] night [right]. I don't know if the people that run this knows but from 5 pm to 6 am [5:00 PM-6:00 AM] it is bad service. They don't answer call lights .It's terrible .Findings employee failed to respond [to the resident's needs and call lights] in timely manner with resident's request stated via resident .explained the routine checks via nursing and ensure .staff would follow protocols. Action taken to correct problem .spoke with CNA about importance of answering call lights timely and to keep resident informed of approx. [approximate] time of arrival .[signed by the DON] . (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 8/23/2022 at 5:58 PM, the DON stated, .when a resident isn't provided care that is neglect the resident's [Resident #551] allegation of neglect .this was not reported and was not investigated because Resident #551 said he just wanted to let someone know about it .I in-serviced the staff . The facility was unable to provide an investigation of the allegation of neglect. Refer to F-600.

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F 0687 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate foot care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38439 Based on policy review, medical record review, observation, and interview, the facility failed to ensure that preventative foot care was provided to prevent pain and decreased mobility. The facility failed to make necessary appointments with podiatrists for 2 of 3 sampled residents (Resident #25 and #93) reviewed for foot care. The facility's failure to identify, assess, report, and provide podiatry services causing pain resulted in actual Harm for Resident #25 and Resident #93. The findings include: Review of the facility's undated policy titled, Resident Rights Notice, revealed .Right to a dignified existence . and Receive Proper Care . Review of the medical record revealed Resident #25 was admitted on [DATE] with diagnoses of Hemiplegia and Hemiparesis affecting Left Dominant Side, Chronic Kidney Disease, and Diabetes. Review of the Care Plan dated 3/22/2022, revealed Resident #25 had Diabetes Mellitus and was at risk of complications from the disease processes, Activities of Daily Living (ADL) Self Care Performance Deficit with interventions to inspect feet daily for open areas, sores, pressure areas, blister, edema, or redness. CNA will report of the above to the Nurses. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #25 had a Brief Interview for Mental Status (BIMS) score of 15, indicating the resident was cognitively intact, required extensive assistance from 1 staff member for Activities of Daily Living (ADL) and uses a wheelchair for mobility. Review of the ADL/Shower Sheets provided dated 5/5/2022, 5/31/2022, and 6/9/2022, revealed Resident #25 received showers and bed baths with no toenail issues identified. No other shower sheets were provided for Resident #25. Review of the Physician Order dated 6/21/2022, revealed a Podiatry consult for evaluation and treatment as indicated. Review of the Physician Order for 7/2022-8/2022 revealed Gabapentin .every 8 hours for pain .Tramadol . every 24 hours as needed for pain at bedtime . Review of the 7/2022 and 8/2022 Medication Administration Record revealed Resident #25 was administered scheduled pain medication as ordered. Review of the Podiatry list for 8/18/2022, revealed Resident #25's name was handwritten on the typed list. Review of the medical revealed Resident #25 was not seen by (Named) Podiatry Services on 6/21/2022 or 8/18/2022. (continued on next page)

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F 0687 Level of Harm - Actual harm Residents Affected - Few	Review of the Weekly Skin Assessments dated 4/28/2022 through 8/22/2022 documented no skin issues and toenails were not identified. Observation in the East Hall on 8/18/2022 at 3:30 PM, revealed Resident #25 was in a wheelchair propelling herself using her right foot wearing tennis shoes and socks. Resident has a diagnosis of hemiplegia affecting left side. During an interview on 8/18/2022 at 3:30 PM, Resident #25 was asked if her toenails were cut today. Resident #25 stated, .no .my toenails are long and they hurt .they need cutting bad they are sticking into my other toe .it hurts .I have to use this foot to get around in my wheel chair .they [staff] told me they were going to cut them but haven't .have you [surveyor] told them and put me on list .they told me I was going to get them cut but they have not .they been like this for a while . Resident #25 confirmed she did not see the Podiatrist on 8/18/22. During a telephone interview on 8/25/2022 at 4:20 PM, the Podiatrist stated, the Podiatrist was asked why Resident #25 had not been seen while at the facility on 8/18/2022. The Podiatrist stated, .must not had her registered properly to be seen .I don't know why .if for some reason resident's need to be seen such as diabetic foot care, pain, or toe nail infection then we should be seeing them .I talked with the DON [Director of Nursing] about this when I was at the facility .someone should be looking at the residents' feet during bathing or showers and putting them on the list to be seen .the ball is being dropped somewhere .if for some reason they are not seen the day we come an Emergency appointment can be made .it definitely concerns me especially for diabetic residents not getting foot care . Observation in the resident's room on 8/26/2022 at 7:59 AM, revealed Licensed Practical Nurse (LPN) #6 pulled back the covers to Resident #25's lower extremities exposing her feet, removed her socks and exposed her toenails, which revealed her toenails to the right foot were hard, dark grayish black and curled and crooked over and under the toes resting on the back of the foot resting on the ball of her feet on all 5 toes and the left foot toenails were just a fraction above the skin straight but the same color and thick as well. During an interview on 8/26/2022 at 7:59 AM, Resident #25 confirmed she is sometimes in pain related to the long unkept and uncut toenails and it is painful to wear shoes. During an interview on 8/26/2022 at 8:01 AM, Licensed Practical Nurse (LPN) #6 was asked how often the Podiatrist comes. LPN #6 stated, .I'm not sure .I thought they saw her [Resident #25] . During an interview on 8/27/2022 at 9:54 AM, the DON was asked if she was aware of the condition of Resident 25's toenails. The DON stated, .No I do not . The DON confirmed toenail care should be addressed on the shower sheets and skin assessment .and on admission . Review of the medical record revealed Resident #93 was admitted to the facility on [DATE] with diagnoses of End Stage Renal Disease, Hypertension, Gout, and Schizophrenia. Review of the Weekly Skin Assessments dated 4/29/2022 through 7/22/2022, documented no skin issues and toenails were not identified. (continued on next page)

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F 0687 Level of Harm - Actual harm Residents Affected - Few	Review of the Shower sheets for 5/25/2022 and 6/13/2022 (the facility only provided 2 shower sheets), revealed Resident #93 received showers and bed baths with no toenail issues identified. Review of the Physician Orders dated 7/6/2022, revealed a Podiatry consult for evaluation and follow up as indicated. Review of the updated Care Plan dated 7/11/2022, revealed .ADL Self Care Performance Deficit .Limited Mobility . There were no interventions related to nail care or pain. Review of the quarterly MDS dated [DATE], revealed a BIMS score of 12, indicating Resident #93 was moderate cognitively impaired, and required assistance from staff with ADLs. Observation in the Lobby on 8/3/2022 at 12:00 PM, revealed Resident #93 had his eyes closed wearing open toe slippers, his toenails were dark and yellow, long and curved over his toes. Observation in the Front Hallway on 8/8/2022 at 5:05 PM, revealed Resident #93 had slippers on revealing long yellow curved toenails. Review of the Podiatry list for 8/18/2022, revealed Resident #93's name was handwritten on the typed list with a notation to see the resident first. Review of the (Named) Podiatry Services Progress Note dated 8/18/2022, revealed .Date 8/18/2022 .nails cut per podiatrist . Review of the Podiatry Service Progress Note dated 8/18/2022, revealed .Reason for Visit: Thick/Myotic [Mycotic] Nails [a fungal infection that affects toenails or fingernails] .Painful on left great toe, left, 2nd toe, left 3rd toe, right great toe right 2nd toe, right 4th toe .Thicken .Brown on left great toe .Dystrophic (deformed thicken and discolored) on left great toe .Incurvated [portion of the nail presses into flesh, causing pain] on left great toe .Alignment .Toes Rigid right and left hammertoe .patient plan performed with nail clippers to reduce thickness and length of all mycotic nails to relieve pain . During an interview on 8/18/2022 at 12:00 PM, Nurse #7 was asked if Resident #93 had his toenails cut today. Nurse #7 stated, .I sure hope so .toenails are bad .he is at dialysis don't know if he did or not .he had started staying in the bed a lot .I asked him why he did not want to get out of bed and he told me 'my toenails too long and they hurt' .he altering his walk .walking on the sides of his feet .he was not seen last visit because of his dialysis they come on his dialysis days so he was not seen last visit . During an interview on 8/18/2022 at 12:30 PM, the Podiatrist was asked if Resident #93's toenails were cut today. The Podiatrist stated, .the resident is at dialysis and has not returned and we are finished seeing patients for the day but if it's an urgent case, I will try to work something out .I will stay and see him . (continued on next page)

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F 0687 Level of Harm - Actual harm Residents Affected - Few	During an interview on 8/18/2022 at 4:30 PM, the DON stated .[Named Resident #93] was not seen by the Podiatrist today because he was gone to dialysis and that [is] why he was not seen last month, they [Podiatry] come on his dialysis days .if he is not seen today we will make arrangements for him to go to a Podiatry clinic .the Social Worker will set up the appointment . The DON was asked why the appointment was not made for emergency foot service when Resident #93 missed his foot service due to dialysis. The DON stated, I don't know, the Social Worker will usually take care of that but since we don't have a Social Worker at this time the acting Social Worker would take care of this . The DON was not aware of Resident #93's nails being trimmed on 8/18/2022. During a telephone interview on 8/25/2022 at 4:20 PM, the Podiatrist stated, I trimmed the resident's toenails on 8/18/2022, I waited for him to get back dialysis and had to wait for a Physician Order .but I stayed. The Podiatrist was asked if the length of Resident #93's toenails would cause pain or change his gait when walking. The Podiatrist stated, .Yes, most definitely. His big toenail was long as one of my fingers and curved. His toenails were in bad shape and should have been identified before now. The staff should have noted the need for nail care and length during shower or bath and reported especially since he was complaining of pain .by the length of the nails, they had not been cut for 6 months or more. The DON is aware of the process of getting us out here, we could do an emergency visit for diabetics, I discussed this with her and if they are having foot pain, we could have done an emergency visit if we had been notified. I was very concerned that they [toenails] were in that bad of shape .Someone is dropping the ball . diabetic foot care is very important and needs to be addressed timely . During an interview on 8/27/2022 at 9:54 AM, the DON was asked where toenails should be documented and when toenails should be assessed. The DON stated, .they [staff] should document on the weekly head to toe assessment .Weekly Skin Assessment and Shower Sheets .the CNAs to make the nurse aware .the nurse reviews Shower Sheets daily . The DON confirmed CNAs should document toenails on the Bath and Shower Sheets, and report abnormal findings to the nurses, and nurses should be assessing the toenails when completing the Weekly Skin Assessment. During an interview on 8/30/2022 at 10:45 AM, the DON was asked about the two (2) Shower sheets provided for Resident #93. The DON stated, .these were the only 2 shower sheets we could find .CNAs [Certified Nursing Assistants] are not allowed to trim nails of diabetics the nurses should review the shower sheet . The facility's failure to identify, assess, report toenails, and provide Podiatry toenail care and services causing pain resulted in actual Harm for Resident #25 and Resident #93.

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

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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** 38439 Based on policy review, police report review, facility investigation review, weather website review, medical record review, observation, and interview, the facility failed to ensure a safe environment to prevent 2 incidents of elopement for 1 of 6 sampled residents (Resident #549) reviewed for elopement and wandering behaviors and the facility failed to ensure a safe environment when unsecured chemicals were in 2 of 60 resident rooms (Resident #17 and #69's rooms). The facility's failure to ensure a safe environment to prevent elopements resulted in Immediate Jeopardy (IJ) when Resident #549 exited the facility without authorization or staff supervision through a malfunctioning exit door. Resident #549 was discovered approximately 372 feet from the PUI Hall (Patient Under Investigation hall is an area designated in the facility for residents who have not received the covid vaccination are monitored for a number of days after hospitalization to ensure they do not show Covid symptoms) exit door, sitting on a bench beside the front entrance. The facility was unaware Resident #549 had exited the building until staff brought him back into the building. Three days later, Resident #549, who was assessed as a risk for elopement, and was wearing a wander guard bracelet (a monitoring device to alert staff of a resident attempting to exit the facility unattended), exited the facility without authorization or staff supervision through the malfunctioning PUI Hall exit door. The PUI Hall exit door did not have a wander guard monitoring system. Staff were unaware of Resident #549's location for approximately 4 hours when he was found at his place of employment approximately 21 miles from the facility. 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 Director of Nursing (DON) were notified of the Immediate Jeopardy on 8/9/2022 at 6:20 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 IJ existed 3/29/2022 and is ongoing. The findings include: (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the facility's undated policy titled, ELOPEMENT, revealed .While wander, door or building alarms can help to monitor a residents activities, staff must be vigilant in order to respond to them in a timely manner, Alarms do not replace necessary supervision, and require scheduled maintenance and testing to ensure proper functioning .Elopement occurs when a resident leaves the premises or a safe area without authorization .and/or any necessary supervision to do so .A resident who leaves a safe area may be a risk of .medical complications or being struck by a motor vehicle .policies that clearly define the mechanisms and procedures for assessing or identifying, monitoring and managing residents at risk for elopement can help minimize the risk of a resident leaving a safe area without authorization and/or appropriate supervision . Chemicals and Toxins .Various materials in the resident environment can pose a potential hazard to residents. Hazardous materials can be found in the form of solids, liquids, gases, mists, dusts, fumes, and vapors. The routes of exposure for toxic materials may include inhalation, absorption, or ingestion .For a material to pose a safety hazard to a resident, it must be toxic, caustic .accessible and available in a sufficient amount to cause harm. Toxic materials that may be present in the resident environment are unlikely to pose a hazard unless residents have access or are exposed to them. Some materials that would be considered harmless when used as designed could pose a hazards to a resident who accidentally ingests or makes contact with them . Review of the facility's policy titled, Abuse Prevention Policy, revised 3/1/2018, revealed .the resident has a right to a safe .environment . Review of a closed medical record, revealed Resident #549 was admitted to the facility on [DATE] with diagnoses of Cerebral Infraction, Hypertension, Schizophrenia, and Bradycardia. Resident #549 signed Against Medical Advice (AMA) and was discharged on [DATE]. Review of the Nurses' Note dated 7/25/2022, revealed .tobacco/alcohol abuse .on 7/5/2022 [prior to admission to this facility] boss not able to reach him [Resident #549] found him in the street nude trying to put his clothes on, confused, unbalanced, and had left sided weakness .ER [emergency room] images revealed an acute infarct [infarction] with chronic infarct. He is functioning beneath baseline .It was thought he would benefit with intense tx [treatment] to increase independence and promote ADL [Activity of Daily Living] .Positive For: left hemiplegia, impaired cognition . Review of the Clinical Admission Evaluation dated 7/22/2022, revealed mental status consisted of disorganized thinking, an unsteady gait, poor balance, abnormalities such as safety concerns and wandered at night. Review of the Nursing Initial 48 Hour Care Plan dated 7/22/2022, revealed .At Risk for Falls due to Fall Assessment score > [greater than] 10 . Review of the Brief Interview for Mental Status (BIMS) dated 7/23/2022, revealed Resident #549 was assessed with a score of 14, indicating he was cognitively intact. Review of the Physical Therapy (PT) Evaluation and (&) Plan of Treatment, dated 7/25/2022, revealed . Reason for Referral: Patient referred to PT due to new onset of decrease in strength, decrease in functional mobility, decrease in transfers, reduced ability to safely ambulate, reduced functional activity tolerance, reduced static dynamic balance, reduced ADL participation and increased need for assistance from others . Patients exhibits knee wobble which are associated with the underlying causes of muscle instability . (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the Speech Therapy (ST) Evaluation & Plan of Treatment dated 7/25/2022, revealed .Pt [patient] presenting with cognitive deficits characterized by decreased attention to tasks (left neglect noted), decreased safety awareness, short term memory, problem solving, calculations and organizational skills . Reason for Referral .Patient referred to ST due to exacerbation of cognitive impairment and decreased safety awareness . Review of the facility's investigation dated 7/27/2022 revealed, .Resident last seen by nurse at 7:05 AM .was seen by another resident walking past her window .Speech Therapist saw resident sitting in front of the building [approximately 372 feet from the exit (PUI Hall) door] and was brought back into the building . 30-minute checks .wander guard applied to resident .instructed maintenance to check all exit doors . Review of the Elopement Risk assessment dated [DATE], revealed Resident #549 was assessed as a high risk for elopement with an intervention to apply a wander guard bracelet with safety checks every 30 minutes. Review of a Nurses' Note dated 7/27/2022, revealed .resident was observed sitting outside on front porch of the facility .resident stated he went outside in search of 'shorts' [cigarettes previously smoked] .resident was assisted back in building .wander guard placed for monitoring .30-minute safety checks . Review of the facility's investigation dated 7/30/2022, revealed .6:40 AM last seeing the resident .Dr. Wander [code for a missing resident] initiated .staff out in cars and on foot .police notified of possible address resident may be located .10:59 AM found resident at [Named] Autobody and Body Panel Shop [approximately 21 miles from facility] .11:30 AM Resident refused to return to facility .signed AMA papers . Resident #549 was not located for approximately 4 hours. Review of a Nurses' Note dated 7/30/2022, revealed .not in assigned room .Staff on foot and in cars searching in progress .Officer also reports resident was seen 30 minutes ago reported by store personnel fitting description .heading downtown area .Day nurse reported resident in past would ask for rides from staff to get to [Named] Road .Emergency contact explains that addresses are his place of business .11:04 am resident located at [Named] Body and Panel Shop .upon discovery of the resident refused return to facility and requested to be discharged AMA . Review of a Police Report narrative dated 7/30/2022, revealed .responded to a missing person .patient had walked away from the scene eastbound between the hours of 0700 [7:00 AM] and 0800 [8:00 AM] .Additional information .at 11:36 [11:36 AM] victim located at [Named] road .11:56 [11:56 AM] officers made the scene with Engine [number] .checked him .released back to caretaker [DON] . According to the Local Weather.com, the high temperature on 7/27/2022 was 82 degrees, and on 7/30/2022 the temperature was 77 degrees and rainy. Review of the Quality Assurance Performance Improvement (QAPI) Root Cause Analysis (RCA) dated 7/27/2022 revealed .[Director of Nursing [DON] not notified of incidences in timely manner .facility failed to complete thorough investigation of elopement .facility failed to obtain signed and dated written statements from staff with knowledge of the incident . (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 8/3/2022 at 12:06 PM, the Speech Therapist stated, .I was treating him [Resident #549] for safety awareness, cognition and not able to reason .I came to work, I recognized him. He was sitting by the front door on a bench, putting smoked cigarettes in his pockets .I assisted him back inside and met his [Named Certified Nursing Assistant (CNA) #2] from the East Hall, and we both carried him back to the Nursing Station, then to his room .the nurses told me they didn't know he was gone .I believe he got out the back door on that hall. I had talked with his RP [Responsible Party] and we discussed the resident need to be able to climb stairs to come home with him .he had no safety awareness .he was very impulsive, unsteady gait and left side neglect .he offered me fifty dollars to take him home .I think the unit manager would take him out to smoke . During an interview on 8/4/2022 at 9:20 AM, Licensed Practical Nurse (LPN) #6 stated, .his [Resident #549] main concern was going back to work .would come to the double door (fire doors) and knock wanting coffee . I did not see him when I came on shift that morning of 7/27/2022 .when he came back we put a wander guard monitor on him, assessed him for smoking, and I took him out to smoke .he told me he went through the plastic and went out the back door (PUI) exit door .he can read, he held it down for 15 seconds and the door opened .I did not hear the door alarm .you have to put in code to cut the alarm off .I checked myself and I pushed on the door it opened but did not alarm .I told maintenance about it . During an interview on 8/4/2022 at 10:08 AM, CNA #2 stated .I got to work late and left .I met the Therapist as I was going out of the door with [Named Resident #549], and I assisted her taking him back to his room . he told me he just wanted to go smoke .he is very unsteady when he walk [walks] .he wanders and never stays in his room, he was in observation . During an interview on 8/4/2022 at 11:40 AM, LPN #4 stated, .around 6:40 AM .I made him coffee and I went to the other hall to get him a sandwich .when I went to do my last check around 7:00 AM on him he was not in his room .Dr. Wander was initiated .I did not hear a door alarm and he did not go past me because I was at the desk and he has akward walk [walked awkwardly], I would have noticed .I knew he was gone I didn't see him anywhere on that hall .I believe he went out the exit door at the end of the hall . During an interview on 8/4/2022 at 3:06 PM, the Maintenance Supervisor was asked when he was made aware the PUI exit door was malfunctioning. The Maintenance Supervisor stated, .I was texted by the Administrator to check the PUI Unit exit door on 7/27 [2022] after an elopement. If the egress (handle) is held for 15 seconds, the door will open, the alarm should sound, and a code would have to be put in to shut it off. I checked the door and when opened the alarm was not sounding .it needed a battery .I did not replace the battery that day .I received another text on 7/30 [2022] from the Administrator about checking the (PUI) exit door .I did not fix the door until 8/1 [2022] .I dropped the ball . The Maintenance Supervisor confirmed the PUI exit door is not equipped with the wander guard monitor system and would not lock down if a wandering resident attempted to exit through the door. The Maintenance Supervisor was asked how often the door alarms are checked. The Maintenance Supervisor stated, .I check the doors, but not every week .probably once a month . (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 8/4/2022 at 3:30 PM, the Administrator stated .I was notified about the elopements, and we determined that he exited through the [PUI] exit door both times. A text message was sent to the Maintenance Supervisor to check all the exit doors and to check the camera footage on 7/27 [2022] .I did not follow up .he texted OK .I was unaware that the PUI exit door was malfunctioning until after the 2nd elopement on 7/30 [2022] .the exit door alarm was not sounding to alert staff when opened .the door should alarm when opened and code put in to cut the alarm off .I am ultimately responsible for the safety and maintenance of the building. The Administrator was asked if there was adequate supervision to monitor and perform 30-minutes checks for Resident #549 on 7/30/2022, if there was knowledge the PUI exit door was malfunctioning. The Administrator stated .he should have been 1 on 1 [1:1] .so he could have been watched more closely . Observation of the PUI Hall exit door on 8/5/2022 at 12:37 PM, the Maintenance Supervisor was checking PUI exit door, the egress (handle) was held for 15 seconds, the door opened, the alarm sounded until he entered the code into a keypad entry. The fire doors to the hall were closed. No staff entered the hall to check the sounding alarm. Three staff members were seated at the desk and did not respond to the alarm. During an interview on 8/5/2022 at 12:37 PM, the Maintenance Supervisor was asked when the alarm was fixed on the PUI exit door. He confirmed it was fixed on Monday, 8/1/2022. The Maintenance Supervisor was asked if he checked to see if the alarm on the PUI hall exit door was loud enough to be heard by staff at the Nurses' Station when the fire doors were closed. He stated, No, I did not .I assumed they could hear it .It will continue to alarm until a code is put in the keypad and it is secured . During an interview on 8/5/2022 at 1:10 PM, Resident #67 stated, .[I] was awake in room between the hours 6:30 AM, and saw a shadow passing by my window .I let him [Resident #549] use my phone to call his employer, all he talked about was going home .he didn't sleep much always up and restless walking up and down the hall .I asked him how he got out when he got out the first time he told me he got out the door [PUI exit door] behind the plastic to find cigarettes to smoke .he brought some back, they were falling out of his pocket on the floor .I did not hear a door alarm neither time he left . During an interview on 8/8/2022 at 12:15 PM, the DON was asked if the wander guard monitor would alarm if a resident with a wander guard exited the PUI exit door. The DON stated .no it would not, only the front and back entrance doors are equipped with the wander guard system. The DON was asked if staffing was adjusted so that Resident #549 could be monitored with 30 minutes safety checks and other wandering residents on the East Hall could be monitored. The DON stated, .I did not check the staffing after the elopement .so I don't know . Observation in Resident #17's room on 8/22/2022 at 1:09 PM, revealed an uncapped bottle of pinkish colored body wash on the resident's sink. Observation in Resident #17's bathroom on 8/22/2022 at 5:42 PM, revealed a gallon of pinkish colored body wash and a spray bottle of a toilet cleaner. Observation in Resident #69's room on 8/23/2022 at 9:55 AM, revealed a gallon of uncapped a pinkish colored body wash and pinkish colored body wash inside a clear plastic cup. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During interview on 8/22/2022 at 1:09 PM, CNA #2 confirmed the uncapped body wash should not be on the sink in a resident's room. During an interview on 8/22/2022 at 5:42 PM, CNA #12 confirmed the unsecured items should not be kept in the residents' rooms. During an interview on 8/23/2022 at 9:55 AM, LPN #6 confirmed the body wash should not be in the resident's room, and she stated, .because one of the residents could get a hold of it and drink it. Refer to F-600

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F 0725 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38440 Based on policy review, review of the facility's staffing documents, review of time detail reports, facility investigation review, medical record review, observation, and interview, the facility failed to maintain sufficient staffing to ensure the safety and supervision of wandering residents and failed to ensure sufficient staff to provide care to residents on 3 of 16 days (7/27/2022, 7/30/2022, and 8/22/2022) reviewed, which had the potential to affect all 94 residents in the facility. The facility's failure to ensure staffing levels were adequate to maintain the safety and supervision of wandering residents placed Resident #549 in Immediate Jeopardy when he exited the building without staff knowledge or supervision, was found outside the facility approximately 45 minutes later, and then exited the building without staff knowledge or supervision 3 days later and was located at an autobody shop approximately 21 miles from the facility approximately 4 hours later. The facility's failure had the potential to affect all 94 residents residing in the facility when 1 Licensed Practical Nurse (LPN) #15 worked in the building providing licensed nursing care for all 94 residents from 1:15 AM until 6:44 AM. Immediate Jeopardy (IJ) is a situation in which a provider's non-compliance with one or more requirements of participation has caused, or is likely to cause, severe injury, harm, impairment, or death to a resident. The Administrator, Director of Nursing (DON), and [NAME] President of Clinical Operations were notified of the Immediate Jeopardy at on 8/26/2022 at 5:48 PM, in the Omega Room. The facility was cited Immediate Jeopardy at F-725. The facility was cited at F-725 at a scope and severity of L, which is Substandard Quality of Care. The IJ was effective on 3/29/2022 and is ongoing. The findings include: Review of the facility's undated policy titled, POSTING DIRECT CARE DAILY STAFFING NUMBERS, revealed .The facility will provide sufficient staff to provide care as needed . Review of a closed medical record, revealed Resident #549 was admitted to the facility on [DATE] with diagnoses of Cerebral Infraction, Hypertension, Schizophrenia, and Bradycardia. Review of the Clinical Admission Evaluation dated 7/22/2022, revealed Resident #549 had disorganized thinking, walked with an unsteady gait and poor balance, and wandered at night. Review of the Brief Interview for Mental Status (BIMS) assessment dated [DATE], revealed Resident #549 had a score of 14, indicating he was cognitively intact. (continued on next page)

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F 0725 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Review of a facility investigation dated 7/27/2022, revealed Resident #549 was found sitting outside in front of the building without staff supervision between 7:45 AM and 7:50 AM, on 7/27/2022, and brought back inside the facility. He was last seen by staff at 7:05 AM. Resident #549 exited the building without staff knowledge and was unsupervised for approximately 45 minutes. Review of the Elopement Risk assessment dated [DATE], revealed Resident #549 was assessed as high risk for elopement. Review of a facility investigation dated 7/30/2022, revealed staff observed Resident #549 at 6:40 AM on 7/30/2022. At 7:05 AM, staff entered Resident #549's room but was unable to locate him until approximately 10:59 AM, when he was located at an autobody shop approximately 21 miles from the facility. Resident #549 exited the building without staff knowledge or supervision and was not located for approximately 4 hours. During an interview on 8/8/2022 at 12:15 PM, the Staffing Coordinator reviewed time detail reports and the assignment sheets for 7/27/2022 and confirmed that there was 1 nurse and 1 Certified Nursing Assistant (CNA) on the East Hall when Resident #549 eloped. During an interview on 8/8/2022 at 12:15 PM, the DON was asked if she was aware there was 1 nurse and 1 CNA on the East Hall when Resident #549 eloped on 7/27/2022. The DON stated .no I was not aware of that .we are having problems with call ins and staff not getting to work on time . The DON was asked if staffing was changed on the East Hall after the elopement on 7/27/2022. The DON stated .no I did not check the staffing . During an interview on 8/10/2022 at 9:30 AM, the Human Resources Director compared time detail reports with the monthly schedule, handwritten assignment sheets, and daily census sheets for dates including 7/26/2022-7/30/2022 and confirmed there was 1 CNA and 1 Nurse on the East Hall on 7/27/2022 when Resident #549 eloped. During an interview on 8/10/2022 at 12:00 PM, CNA #9 stated .when I got to work, I started my rounds down by room [number] .I did not know if any other CNAs were here .I did not know he [Resident #549] had got [gotten] out until he was back, and I heard the nurses at the desk talking . The facility failed to ensure sufficient staffing to maintain the safety and security of wandering residents. Review of the staff assignment sheets, and time detail reports dated 8/21/2022 and 8/22/2022, revealed LPN #15 was the only nurse in the building between 1:15 AM and 6:44 AM on 8/22/2022. The census on 8/21/2022 was 94. (continued on next page)

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F 0725 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	During an interview on 8/24/2022 at 10:00 AM, LPN #15 confirmed he was the only nurse in the building on 8/22/2022 between 1:15 AM and 6:44 AM. LPN #15 stated, I had to pass meds [medications], I had to hang [enteral] feedings .I did the best I could, there was supposed to be a nurse that came in at 11 [11:00 PM on 8/21/2022] but she never showed. LPN #15 was asked how many nurses are usually scheduled on night shift on the weekend. LPN #15 stated, There are usually 2 nurses on each unit .The other nurse called staffing and asked where the one who was supposed to show up at 11 was . LPN #15 was asked if he felt it was safe to be the only nurse in the building for 94 residents. LPN #15 stated, Like I said, I did the best I could. During an interview on 8/24/2022 at 11:06 AM, the Staffing Coordinator was asked how many nurses usually work the night shift. The staffing Coordinator stated, 3. The Staffing Coordinator was asked if there are ever less than 3 nurses working night shift. The Staffing Coordinator stated, Yes .1 or 2 days a week . The Staffing Coordinator was asked how many nurses usually work the night shift on the weekends. The Staffing Coordinator stated, .I try to keep 4 .I don't want anybody to be overwhelmed . The Staffing Coordinator was asked how many CNAs usually work on the day shift. The Staffing Coordinator stated, .6. The Staffing Coordinator was asked how many CNAs usually work on the night shift. The staffing Coordinator stated, .5. The Staffing Coordinator confirmed she attempts to cover call ins and makes the DON aware of staffing shortages. The Staffing Coordinator was asked who covers for licensed staff if someone calls in. The Staffing Coordinator stated, .you are supposed to have backup nurses and managers and everything. I am supposed to call the DON and she is supposed to call them .I keep calling. I do not stop at her [the DON] .I call, and I beg, and I put it on on-shift [an employee messaging system] .some nurses will be like, they need more [a larger bonus] and I go to [Named DON] .2 nurses called in today and they [the nurses called and asked to come in] laughed . The Staffing Coordinator was asked does the DON come in if you are not able to find coverage for a nurse. The Staffing Coordinator stated, .No, she does not . The Staffing Coordinator confirmed that one nurse worked in the building from 1:15 AM-6:44 AM on the morning of 8/22/2022. The staffing coordinator confirmed that she sent a message to the DON about the staffing issue, and she asked the nurse leaving at 1:15 AM [LPN #9], to message the Assistant Director of Nursing (ADON) and the Unit Managers about the situation. The Staffing Coordinator was asked if she thought it was safe to have 1 nurse in the building to provide care for 94 residents. The Staffing Coordinator stated, No .nobody answered [when calls were made to staff] . During an interview on 8/24/2022 at 5:43 PM, the DON was asked if she was aware that there was only 1 nurse in the building from 1:15 AM-6:44 AM on the morning of 8/22/2022. The DON stated, No, I didn't get that until the next morning. I was traveling .I was out of town, so my phone did not show any call ins and I didn't have any messages. The DON was asked if she thought it was safe for 1 nurse to care for 94 residents. The DON stated, No . The DON was asked who was ultimately responsible for making sure there are enough nurses and CNAs in the building to care for the residents. The DON stated, I am. (continued on next page)

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

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F 0725 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	During an interview on 8/28/2022 at 4:52 PM, LPN #9 confirmed that she came in at 7:00 AM on 8/21/2022 and worked until 1:15 AM on 8/22/2022, leaving 1 nurse in the building. LPN #9 stated, The nurse that was supposed to be here was not here yet .[Named person] .said she would try to call the nurse and see where she was. She told me to send out a group text to the 2 Unit Managers, the Assistant Director of Nursing [ADON], the DON, and include her in the text, and let them know that she [the nurse scheduled to come in at 11:00 PM] hadn't come in and that I had been here since 7 [7:00 AM] that morning. LPN #9 was asked if anyone responded to the text. LPN #9 stated, Only the Staffing Coordinator. LPN #9 was asked how were staffing problems handled. LPN #9 stated, We call the staffing Coordinator and notify the DON .In the past, they have had nurses that were on call should a situation occur. LPN #9 was asked when the on-call system stopped. LPN #9 stated, About a year ago. LPN #9 was asked how many nurses usually come in on weekends on the 7:00 PM to 7:00 AM shift. LPN #3 stated, Usually at least 3. LPN #9 was asked if it was safe to only have 1 nurse in the building at night. LPN #9 stated, No, not at all. During an interview on 8/29/2022 at 5:37 PM, the ADON confirmed she received a text between 5:00 PM or 6:00 PM stating that the facility needed a nurse to come in at 7:00 PM but did not get a text about the nurse not coming in at 11:00 PM. The ADON was asked who was responsible for covering for the DON if she is not available. The ADON stated, Technically it would be me. The ADON was asked if she knew the DON was going to be unavailable on 8/21/2022. The ADON stated, No ma'am. During an interview on 8/30/2022 at 5:48 PM, LPN #13 confirmed she received a text message from LPN #9 on 8/22/2022 at 12:12 AM, stating that her relief had not shown up and she had been at the facility since 7:00 AM the morning before. LPN #13 confirmed she did not reply to the text message because she did not see it until she woke up on 8/22/2022.

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F 0744 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39436 Based on policy review, medical record review, observation, and interview, the facility failed to provide care and services to meet each resident's Dementia care and behavior needs and failed to provide behavior monitoring for 3 of 9 sampled residents (Resident #14, #25, and #29) reviewed for Dementia care and behaviors. The facility's failure to provide care and services for Dementia and behaviors resulted in Immediate Jeopardy when Resident #14, with a history of inappropriate sexual behaviors, verbally threatened to beat and rape Resident #25, and touched Resident #29's breast. The facility's failure resulted in Immediate Jeopardy (IJ) for Resident #14, #25, and #29. 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 [NAME] President (VP) of Clinical Operations, Administrator, and the Director of Nursing (DON) were notified of the Immediate Jeopardy for on 8/26/2022 at 5:48 PM, in the Omega Room. The facility was cited Immediate Jeopardy at F-744. The facility was cited at F-744 at a scope and severity of K, which is Substandard Quality of Care. The Immediate Jeopardy existed on 3/29/2022 and is ongoing. The findings include: Review of the facility's policy titled, Mood and Behavior Policy, reviewed 11/18/ 2021, revealed .each resident must receive and the facility must provide the necessary behavioral health care and services .to attain or maintain the highest practicable physical, mental and psychosocial well-being .provide a plan of care that is individualized to the residents' needs .behavioral symptoms that may cause distress or are potentially harmful to the resident, or may be distressing or disruptive to .residents, staff members or the environment .identifying potential mood and behavior changes, support and care plan interventions .mood and behavior tracking documentation will be completed .will be reviewed by the interdisciplinary team .to determine trends and effectiveness of care plan .if resident displays behaviors or mood changes that are a potential danger to the safety, health or welfare of themselves or others, the interdisciplinary team will assess the resident's current status .make appropriate intervention . (continued on next page)

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F 0744 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of the facility's policy titled, Abuse Prevention Policy, reviewed 11/1/2021, revealed .the resident has the right to be free from verbal, sexual, physical, and mental abuse .neglect and misappropriation of property .Abuse .intimidation .depravation .of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being. Abuse may be resident to resident, staff to resident .Verbal abuse .use of oral .language that .includes disparaging and derogatory terms .Sexual abuse includes but not limited to sexual harassment, sexual coercion, or sexual assault .Neglect means failure to provide goods and services necessary to avoid physical harm .When abuse, neglect or exploitation is suspected .respond to the needs of the resident, and protect them from further abuse . Review of the medical record, revealed Resident #14 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses of Chronic Kidney Disease, Diabetes, Protein-Calorie Malnutrition, Alcohol Abuse, Anxiety Disorder, and Depression. Review of Resident #14's referral from another skilled nursing facility dated 10/18/2021, revealed .verbally aggressive towards a female resident .get things for him and trying to make her smoke .resident appeared to get angry .resident observed rubbing the arm of the female resident. The female resident asked the resident to stop but he would not .resident inappropriately grabbed a female resident on her buttocks while in the dining room . Review of the Progress Note dated 3/29/2022, revealed .Resident displaying inappropriate sexual behavior. Resident grabbing at staff members and descriptively describing their body parts. Resident stated, I'm going [explicit language] the [explicit language] out of them. Resident then stated to niece on phone I'm just [explicit language] with them and asking about their [explicit language] .resident stated I want one of yall [y'all] to hit me so I can slap the [explicit language] out of yall [y'all] put me out. Resident cursing staff . Review of the Progress Note dated 3/30/2022, revealed .On 3/29/22 [2022], the SW [Social Worker] was informed that the resident grabbed the buttocks of a housekeeper and then attempted to grab the activities assistant vaginal [the Activity Assistant's vagina]. The resident was making [NAME] and inappropriate comments and offer the staff money for sex. The SW talked to the resident who then admitted to the behaviors and then attempted the grab the SW. The SW went to the DON's office to report the incident. The resident was asked to come into the DON's office to talk about the incident. The resident admitted what he was accused of and then proceeded to call the staff [explicit language]. While the DON continued to talk with the resident about his behavior, the resident stated that if the SW wanted to hit him in the face that he would beat her [Explicit Language]. The resident then proceeded to come towards the SW in a threating manner. The DON stopped the resident and stated that the resident was attempting to provoke the SW and that she could be fearing for her safety. The resident attempted to come up on the SW at least three times while in the DON's office. The SW then left and went to her office and contacted the resident's family to report the incident. When the brother arrived, the SW escorted him to the DON's office where the resident's behavior was discussed. The brother stated that he wanted to take the resident out on LOA [leave of absence] to have a talk with him. At this time the SW has not seen the resident but will continue to report sexual inappropriate behavior as needed . Review of a quarterly Minimum Data Set (MDS) dated [DATE], revealed Resident #14 was assessed with a Brief Interview for Mental Status (BIMS) of 6, indicating severe cognitive impairment for decision making, displayed physical behavior symptoms toward others, and verbal behaviors toward others. (continued on next page)

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F 0744 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of the Progress Note dated 3/31/2022, revealed .new problem. Staff reports he has been grossly verbally and physically inappropriate with female staff including threats of physical harm . Review of Resident #14's Care Plan dated 3/21/2022, revealed the Care Plan was not updated until 6/20/2022 to reflect inappropriate sexual behaviors. Review of a quarterly MDS dated [DATE], revealed Resident #14 was assessed with a BIMS of 10, indicating moderate impairment for daily decision making. Medical record review revealed, Resident #25 was admitted to the facility on [DATE] with diagnoses of Chronic Kidney Disease, Diabetes, Bipolar Disorder, Depression, Hemiplegia and Hemiparesis. Review of the quarterly MDS dated [DATE], revealed Resident #25 was assessed with a BIMS of 15, indicating the resident was cognitively intact. Review of Resident #14's Progress Note dated 6/17/2022, revealed .On yesterday, the resident [Resident #14] rolled up behind a female resident [Resident #25] and threatened her by stating, 'I am going to beat your [explicit language].' The female resident [Resident #25] notified this SW who then talked to the DON and psych [psychiatric] services. The resident [Resident #14] continues to be on psychiatric case load. Family will be notified today . During an interview on 8/18/2022 at 4:15 PM, the [NAME] President (VP) of Clinical Operations stated, . [Named Resident #14] was placed 1 on 1 because of the incident involving a verbal threat of rape made to [Named Resident #25] . Review of the Care Plan revealed there were no interventions added after the incident on 6/17/2022 to monitor Resident #25 for any negative outcomes related to verbal threats of physical and sexual abuse. Review of the medical record revealed, Resident #29 was admitted to the facility on [DATE] with diagnoses of Intellectual Disabilities, Psychosis, Anxiety Disorder, and Insomnia. Review of the quarterly MDS dated [DATE], revealed Resident #29 was assessed with a BIMS of 2, indicating the resident was severely cognitively impaired. Review of Care Plan revealed there were no interventions to monitor Resident #29 for any negative outcomes related to the sexual abuse allegation that occurred on 7/14/2022. Review of Resident #14's Physician's Progress Note dated 7/14/2022, revealed .increased sexual behaviors . [Resident #14] feeling on resident's [Resident #29] breast. Psych is following . Review of Resident #14's Psychiatric Nurse Practitioner Progress Note dated 7/14/2022, revealed .asked to see [Resident #14] ahead of scheduled visit due to same problems staff reports he touched a female resident [Resident #29] inappropriate on her breasts today. This is a pattern of behavior for this resident . says the female resident invited him to touch her. Pointed out that she has little verbal and is not capable of that .continued to deny responsibility .more angry outbursts are occurring .continued instances of impulsive behaviors .Non pharm [pharmacological] interventions have been ineffective . (continued on next page)

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F 0744 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 8/18/2022 at 4:15 PM, the [NAME] President (VP) of Clinical Operations stated, . Resident #14 was placed 1 on 1 because of the incident .touching a resident's [Resident #29] breast . Review of Resident #14's Care Plan revealed there were no new interventions added for the sexually inappropriate behavior with Resident #29. The facility failed to monitor Resident #25 and Resident #29 for outcomes related to verbal and sexual abuse. During an interview on 8/18/2022 at 5:05 PM, Licensed Practical Nurse (LPN) #13 stated, .monthly behavior meeting .unit managers, Assistant Director of Nursing (ADON), the Director of Nursing and the Psychiatric Nurse Practitioner attend the meeting .weekly meeting is Unit Managers, Social Worker, and Assistant Director of Nursing .review the 24 hour report to see if any behaviors exhibited .the Psych Nurse Practitioner sends a list of residents with medications and why they're on the medications .discuss behaviors exhibited . interventions how to address the situation .update plan of care .review the PAR [Patient At Risk] notes .and medication changes . During an interview on 8/12/2022 at 1:54 PM, the DON was asked what should be done for the residents involved in incidents of abuse. The DON stated, .increase the monitoring of the residents that are involved in incidents of abuse .

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Administer the facility in a manner that enables it to use its resources effectively and efficiently. 38439 Based on policy review, job description review, and interview, Administration failed to provide oversight to ensure systems and processes were developed and consistently followed, failed to provide oversight of nursing staff, failed to identify the root cause of concerns identified in the facility, and failed to ensure systems and processes were developed and consistently followed by facility staff. Administration failed to provide oversight that established and implemented policies and procedures to ensure residents were free from verbal, physical, sexual abuse, and misappropriation of property. Administration failed to provide oversight that established and implemented policies and procedures to ensure resident behaviors were monitored, assessed, and identified. Administration failed to provide oversight that established and implemented policies and procedures to ensure facility staff investigated abuse allegations thoroughly. Administration failed to provide oversight that established and implemented policies and procedures to ensure abuse allegations were reported timely to all respective entities. Administration failed to provide oversight that established and implemented policies and procedures to ensure a safe and secure environment when Resident #549 exited from the facility on 2 separate occasions, 3 days apart through the same malfunctioning door without staff knowledge. Administration failed to provide oversight that established and implemented policies and procedures to ensure the facility had sufficient numbers of staff to provide care and services to residents when 1 newly hired Licensed Practical Nurse (LPN) #15 was left to work alone in the facility with 94 residents. Administration failed to provide oversight that established and implemented policies and procedures to ensure the facility provided effective housekeeping and maintenance services to maintain a sanitary, orderly, and comfortable environment. Administration failed to provide oversight that established and implemented policies and procedures to ensure foot care was provided for Resident #25 who had foot pain and Resident #93 who stopped wearing shoes and walked with difficulty and pain due to long toenails. These failures resulted in Immediate Jeopardy for Resident #5, #14, #25, #29, #30, #50, #72, #549, #550, and #551, actual Harm for Resident #25 and Resident #93, and Substandard Quality of Care in environment. 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 Director of Nursing (DON) were notified of the Immediate Jeopardy (IJ) for F-689 during the complaint investigation on 8/9/2022 at 6:20 PM, in the Omega Room. The Administrator and the Director of Nursing were notified of the Immediate Jeopardy (IJ) for F-600 and F-610 during the complaint investigation on 8/12/2022 at 2:50 PM, in the Omega Room. The Administrator and the Director of Nursing were notified of the Immediate Jeopardy (IJ) for F-609 and F-725 on 8/24/2022 at 7:03 PM, in the Omega Room. The [NAME] President of Clinical Operations, the Administrator, and the Director of Nursing were notified of the Immediate Jeopardy (IJ) for F-744, F-835, and F-867 on 8/26/2022 at 5:48 PM, in the Omega Room. (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	The [NAME] President of Clinical Operations and the Regional Director of Clinical Operations were notified of the Immediate Jeopardy (IJ) for F-837 on 8/30/2022 at 12:04 PM, in the Omega Room. The facility was cited Immediate Jeopardy at F-600, F-609, F-610, F-689, F-725, F-744, F-835, F-837, and F-867. The facility was cited at F-725, F-835, F-837 and F-867 at a scope and severity of L. The facility was cited at F-600, F-609, F-610, and F744 at a scope and severity of K, at F-584 at a scope and severity of F, and at F-689 at a scope and severity of J, which is Substandard Quality of Care. The Immediate Jeopardy existed from 3/29/2022 and is ongoing. The findings include: The facility's signed Administrator job description date of 3/1/2022, revealed .Administration .The primary purpose of your job 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 of care can be provided to our residents at all times .you are delegated the administrative authority, responsibility, and accountability necessary for carrying out your assigned duties .Ensure that all employees, residents, visitors and the general public follow the facility's established policies and procedures . make written and oral reports/recommendations to the governing board concerning the operation of the facility .Make routine inspections of the facility to assure that established policies and procedures are being implemented and followed .Assume the administrative authority, responsibility and accountability of directing the activities and programs of the facility .Serve on various committees of the facility .Quality Assurance [QA] .and provide written/oral reports .to the governing board as directed .Assist the Quality Assurance and Assessment Committee in developing and implementing appropriate plans of action to correct identified quality deficiencies .Consult with department directors concerning the operation of their department to assist in eliminating/correcting problem areas, and/or improvement of services .Ensure that an adequate number of appropriately trained licensed professional and non-licensed personnel are on duty at all times to meet the needs of the residents .Ensure that appropriate staffing level information is posted on a daily basis .Schedule and participate in departmental meetings to ensure that appropriate information sharing is provided on a continuous basis .Inform the Medical Director of all suspected or known incidents of resident abuse .assure the facility is maintained in a clean, safe and sanitary manner .Ensure that the facility is maintained in a clean and safe manner for resident comfort and convenience . (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	The facility's signed Director of Nursing job description dated 7/13/2021, 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 .you are delegated that administrative authority, responsibility, and accountability necessary for carrying out your assigned duties. In the absence of the Medical Director, you are charged with carrying out the resident care policies established by this facility . Plan, develop, organize, implement, evaluate, and direct the nursing service department .in accordance with current rules, regulations, and guidelines that govern the nursing care facilities .Make written and oral reports/recommendations to the Administrator, as necessary/required concerning the operation of the nursing service department .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 .Assist in calculating the number of direct nursing care personnel on duty each shift. Report such information to the Administrator his/her designee to ensure that accurate staffing information is posted .Ensure that all resident care rooms .are maintained in a clean, safe and sanitary manner .Review complaints and grievances made by the resident and make a written/oral report to the Administration indicating what action(s) were taken to resolve the complaint or grievance .Report and investigate all allegations of resident abuse and/or misappropriation of resident property . During an interview on 8/26/2022 at 4:58 PM, the Administrator and the Director of Nursing (DON) were asked if the facility's QA/Quality Assurance Performance Improvement (QAPI) program was effective since the last survey, less than 11 months ago when the facility was cited for the same deficiencies at an Immediate Jeopardy level. The Administrator shrugged her shoulders in an up and down motion and did not answer the question. The Administrator was asked who was responsible for the behavior monitoring program. The Administrator confirmed the DON was responsible. The Administrator was asked if the facility had an effective behavior monitoring program in the event vulnerable residents are at risk for abuse and abuse allegations are made. The Administrator did not respond. The Administrator confirmed that there should be sufficient staff in the facility to meet residents' highest practicable well-being and no staff member should be left in the building alone with 94 residents. The Administrator was asked should allegations of physical, verbal, sexual abuse and misappropriation of property be reported and thoroughly investigated. The Administrator confirmed that all abuse should be thoroughly investigated, and the facility policy should be followed. The Administrator was asked who was ultimately responsible for the residents' highest practicable well-being, to ensure there was sufficient staffing in the facility, ensure procedures were followed, to monitor resident behaviors, to ensure allegations of verbal, sexual, physical abuse, and misappropriation of resident property was identified, reported, and thoroughly investigated, and to ensure residents resided in a safe, secure, and sanitary environment. The Administrator confirmed she was ultimately responsible for the well-being of all residents along with the DON who was responsible for ensuring all medical needs of the residents were met. During an interview on 8/27/2022 at 8:00 AM, the [NAME] President (VP) of Clinical Operations confirmed administration was ineffective. (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	During a telephone interview on 8/30/2022 at 8:01 AM, the Chief Operating Officer (COO) was asked who reports directly to her. The COO confirmed the VP of Clinical Operations and the Regional Director of Clinical Operations along with the Administrators report directly to her in some instances. The COO was asked what things they report to her. The COO confirmed any risk management issues are reported directly from the Administrator to both the VP and the COO in an ongoing email communication system. The COO stated, Those are mandatory things that have to be reported along with any elopements . The COO was asked if allegations of physical, sexual, verbal abuse, and misappropriation of resident's property, and elopement were reported to her. The COO confirmed these are circumstances that would be reported directly to the COO and the VP from the Administrator. The COO stated, .we (VP and COO) were not (informed) this is where administratively the process failed . The COO confirmed the Administrator should have reported any allegation of abuse, misappropriation of property and elopement. The COO was asked if she was made aware of the allegation of misappropriation of property for Resident #25 that was reported to the Director of Nursing (DON) on 8/27/2022. The COO confirmed that all allegations of abuse and misappropriation should be reported to both the Regional Director of Clinical Operations and to the VP and the COO immediately, and it should be investigated when it occurs. The COO confirmed she was made aware of the allegation on 8/29/2022 on the date that the VP was made aware of the allegation, and it should have been investigated and reported the day it occurred on 8/27/2022. She confirmed administration failed to do so. The COO was asked if she believed the building was in disrepair and needed repairs. The COO confirmed the environment had significantly deteriorated, was not up to appropriate standards, and needed repairs and preventative maintenance. She confirmed it needed some improvements and was not acceptable. The COO confirmed this was information that should have been reported by the Administrator. The COO confirmed department managers were responsible for reporting anything significant that has occurred, and the Administrator should follow up. The COO stated, The facility failed to report and to seek help to be guided through those things . because of that the step was missed and that is why we are where we are now . The COO was asked was the Administration in the building effective. The COO stated, Absolutely not . The Administration failed to maintain oversight, establish, and implement policies and procedures to ensure allegations of abuse are thoroughly investigated, and reported. Refer to F-600, F-609 and F-610. The Administration failed to maintain oversight, establish, and implement policies and procedures to ensure adequate staffing. Refer to F-725. The Administration failed to maintain oversight, establish and implement policies and procedures to ensure behavior monitoring for residents. Refer to F-744. The Administration failed to maintain oversight, establish, and implement policies and procedures to ensure an effective QAPI program was in established in the facility. Refer to F-867.

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	08/30/2022

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0837 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Establish a governing body that is legally responsible for establishing and implementing policies for managing and operating the facility and appoints a properly licensed administrator responsible for managing the facility. 38439 Based on policy review, job description review, and interview, the Governing Body failed to provide oversight to ensure systems and processes were developed and consistently followed by facility staff and failed to provide oversight of administration and nursing staff, failed to identify the root cause of concerns identified in the facility. The Governing Body failed to provide oversight that established and implemented policies and procedures to ensure residents were free from verbal, physical, sexual abuse, and misappropriation of property. The Governing Body failed to provide oversight that established and implemented policies and procedures to ensure facility staff investigated abuse allegations thoroughly. The Governing Body failed to provide oversight that established and implemented policies and procedures to ensure abuse allegations are reported or reported timely to the respective entities. The Governing Body failed to provide oversight that established and implemented policies and procedures to ensure Resident #549 was assessed for exit seeking behaviors and monitored when he exited from the facility on 2 separate occasions, 3 day apart through the same malfunctioning door. The Governing Body failed to provide oversight that established and implemented policies and procedures to ensure facility had sufficient numbers of staff to provide care and services to residents when 1 newly hired Licensed Practical Nurse (LPN) #15 was left to work alone in the facility with 94 residents. The Governing Body failed to provide oversight that established and implemented policies and procedures to ensure residents behaviors were monitored, assessed, and identified. The Governing Body failed to provide oversight that established and implemented policies and procedures to ensure the facility provided effective housekeeping services and maintenance services to maintain a sanitary, orderly, and comfortable environment. The Governing Body failed to provide oversight that established and implemented policies and procedures to ensure foot care was provided for Resident #25 who had foot pain and Resident #93 who stopped wearing shoes and walked with difficulty and pain due to long toenails. These failures resulted in Immediate Jeopardy for Resident #5 #14, #25, #29, #30, #50, #72, #549, #550, and #551, actual Harm for Resident #25 and Resident #93, and Substandard Quality of Care in environment. 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 Director of Nursing (DON) were notified of the Immediate Jeopardy (IJ) for F-689 during the complaint investigation on 8/9/2022 at 6:20 PM, in the Omega Room. The Administrator and the Director of Nursing were notified of the Immediate Jeopardy (IJ) for F-600 and F-610 during the complaint investigation on 8/12/2022 at 2:50 PM, in the Omega Room. The Administrator and the Director of Nursing were notified of the Immediate Jeopardy (IJ) for F-609 and F-725 on 8/24/2022 at 7:03 PM, in the Omega Room. The [NAME] President of Clinical Operations, the Administrator, and the Director of Nursing were notified of the Immediate Jeopardy (IJ) for F-744, F-835, and F-867 on 8/26/2022 at 5:48 PM, in the Omega Room. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0837 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	The [NAME] President of Clinical Operations and the Regional Director of Clinical Operations were notified of the Immediate Jeopardy (IJ) for F-837 on 8/30/2022 at 12:04 PM, in the Omega Room. The facility was cited Immediate Jeopardy at F-600, F-609, F-610, F-689, F-725, F-744, F-835, F-837, and F-867. The facility was cited at F-600, F-609, F-610, and F-744 at a scope and severity of K, at F-584 at a scope and severity of F, and at F-689 at a scope and severity of J, which is Substandard Quality of Care. The Immediate Jeopardy existed from 3/29/2022 and is ongoing. The findings include: Review of the facility's policy titled, Governing Body Policy F837 . dated 9/19/2021, revealed .The Governing Body assumes full legal responsibility for the overall conduct of the facility and shall be responsible for compliance with applicable laws and regulations pertaining to the facility .will include, but not be limited to . Licensed Administrator .Director of Nursing .Director of Quality Assurance .Medical Director .the Governing shall meet as needed but no less frequently than annually and shall record minutes .The Governing Body has the authority to appoint .responsible for the interpretation, implementation, and proper application of policies and programs .The administrator reports and is accountable to the Governing Body regarding the day-to-day operations and management of the facility .The Governing Body will ensure that policies and procedures .including such operational matters as .Regulatory Survey results .Allegations of Abuse and Neglect .Internal Quality Audits .Budget .Staffing levels . Review of the facility's signed Administrator job description dated of 3/1/2022, revealed .Administration .The primary purpose of your job 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 of care can be provided to our residents at all times .you are delegated the administrative authority, responsibility, and accountability necessary for carrying out your assigned duties . Ensure that all employees, residents, visitors and the general public follow the facility's established policies and procedures .make written and oral reports/recommendations to the governing board concerning the operation of the facility .Make routine inspections of the facility to assure that established policies and procedures are being implemented and followed .Assume the administrative authority, responsibility and accountability of directing the activities and programs of the facility .Serve on various committees of the facility (.Quality Assurance .and provide written/oral reports .to the governing board as directed .Assist the Quality Assurance and Assessment Committee in developing and implementing appropriate plans of action to correct identified quality deficiencies .Consult with department directors concerning the operation of their department to assist in eliminating/correcting problem areas, and/or improvement of services .Ensure that an adequate number of appropriately trained licensed professional and non-licensed personnel are on duty at all times to meet the needs of the residents .Ensure that appropriate staffing level information is posted on a daily basis .Schedule and participate in departmental meetings to ensure that appropriate information sharing is provided on a continuous basis .Inform the Medical Director of all suspected or known incidents of resident abuse .assure the facility is maintained in a clean, safe and sanitary manner .Ensure that the facility is maintained in a clean and safe manner for resident comfort and convenience . (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0837 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Review of the facility's signed Director of Nursing job description dated 7/13/2021, 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 Medial Director, to ensure that the highest degree of quality care is maintained at all times .you are delegated that administrative authority, responsibility, and accountability necessary for carrying out your assigned duties. In the absence of the Medical Director, you are charged with carrying out the resident care policies established by this facility .Plan, develop, organize, implement, evaluate, and direct the nursing service department .in accordance with current rules, regulations, and guidelines that govern the nursing care facilities .Make written and oral reports/recommendations to the Administrator, as necessary/required concerning the operation of the nursing service department .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 . Assist in calculating the number of direct nursing care personnel on duty each shift. Report such information to the Administrator his/her designee to ensure that accurate staffing information is posted .Ensure that all resident care rooms .are maintained in a clean, safe and sanitary manner .Review complaints and grievances made by the resident and make a written/oral report to the Administration indicating what action(s) were taken to resolve the complaint or grievance .Report and investigate all allegations of resident abuse and/or misappropriation of resident property . During an interview on 8/26/2022 at 4:58 PM, the Administrator and the DON confirmed the Administrator is ultimately responsible for the well-being of all residents along with the DON who is responsible for ensuring all medical needs of the resident are met. During an interview on 8/27/2022 at 8:00 AM, the [NAME] President of Clinical Operations confirmed the administration was ineffective. During a telephone interview on 8/29/2022 at 3:53 PM, the Medical Director was asked how she communicates with the Administrator and DON. The Medical Director stated, Usually I will talk to the DON every time I come in .the Administrator I really haven't had much dealings with her. The Medical Director was asked if she thought the facility had an effective Quality Assurance and Performance Improvement (QAPI) program and if she had been part of the decision making for the facility. The Medical Director stated, I think it's a work in process. The Medical Director was asked if she had been made aware of the environmental issues, and if the facility had a homelike environment. The Medical Director stated, It's a work in progress. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0837 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	During a telephone interview on 8/30/2022 at 8:01 AM, the Chief Operating Officer (COO) was asked what her job duties consisted of. The COO stated, I oversee the operations of 14 nursing homes .I have an operation team that reports to me .the Regionals report to the [NAME] President (VP), and the VP reports to me .I report to the President of the company. The COO was asked what type of things does the VP report. The COO stated, .QAPI mock surveys, plan of corrections .reports all regulatory violations .elopements .falls with injuries .emergent staffing issues . The COO was asked if she was made aware that a resident exited the building on 7/27/2022. The COO stated, We were not, this is where administratively, they failed. The COO was asked should she have been made aware. The COO stated, Yes that is a requirement . The COO was asked if she was made aware of the abuse allegations. The COO stated, No Ma'am .I can't say if they were reported to the [Named Regional] at the time .those situations are a potential for harm and should have been reported .we were not made aware of the grievances related to misappropriations of funds . The COO was asked when there was an allegation of abuse, should it be investigated and reported immediately. The COO stated, Yes. The COO was asked if there was a report of misappropriation that was reported on Saturday, would she expect the investigation to start on a Monday. The COO stated, No .it should have been investigated immediately. The COO was asked who makes up the Governing Body. The COO stated, The Director of Nursing, the Administrator, the Medical Director, the Regional and the management team. The COO was asked if she thought the facility was a home like environment for the residents. The COO stated, I feel like the environment has digressed .preventable maintenance needed .and it was not acceptable at all . The COO was asked if she had been notified of the events that have happened in the last 4-5 weeks. The COO stated, No, not of the things you have identified. They did not follow procedure . The COO was asked how she provided oversite and ensure the facility is effective in providing care and services. The COO stated, My oversight is to ensure the VP has the Regional trained on policies and procedures. The COO was asked does the facility report to her and how often. The COO stated, Directly to me, No, the Regional reports to the VP .we have a group email .the facility has failed to report those issues .this is why we are where we are right now. The COO was asked if she thought your administration has been effective. The COO stated, No . The COO was asked did she think her Regional was very effective. The COO stated, No he wasn't, I think we failed in giving him proper oversight. The Governing Body failed to maintain oversight to provide consistent Administrative staff including an Administrator and Director or Nursing. Refer to F-835 The Governing Body failed to maintain oversight, establish, and implement policies and procedures to ensure allegations of abuse are thoroughly investigated and reported. Refer to F-600, F-609, and F-610. The Governing Body failed to maintain oversight, establish, and implement policies and procedures to ensure adequate staffing. Refer to F-725. The Governing Body failed to maintain oversight, establish, and implement policies and procedures to ensure behavior monitoring for residents. Refer to F-744. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0837 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	The Governing Body failed to maintain oversight, establish, and implement policies and procedures to ensure an effective QAPI program was in established in the facility. Refer to F-835 and F-867.

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(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 - Many	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. 38439 Based on policy review, review job description review, and interview, the facility failed to ensure an effective Quality Assurance Performance Improvement (QAPI) program that recognized ongoing problems with resident safety to prevent, identify, report, and thoroughly investigate, allegations of abuse, neglect, and misappropriation. The QAPI committee failed to assure the facility was administered in a manner to use its resources effectively and efficiently, and that the [NAME] President of Clinical Operations assisted the facility with identifying, evaluating, addressing clinical concerns, coordinating the care, and providing clinical guidance and oversight. Failure of the facility to implement and/or provide interventions to maintain safety of the residents and ensure the residents highest quality of care resulted in the likelihood of a serious event when Resident #549 exited the facility without staff knowledge or supervision on 2 separate occasions, 3 days apart, through a malfunctioning exit door. The QAPI committee program failed to identify the root cause of elopement. The facility failed to report and thoroughly investigate allegations of resident-to-resident abuse, verbal and sexual abuse, and misappropriation of resident property. The QAPI committee failed to monitor ongoing behaviors for sexual abuse and failed to implement safety measures for residents related to abuse. The facility failed to provide sufficient staffing to provide care and services, promote the residents' highest practicable well-being when 1 Licensed Practical Nurse (LPN) #15 was assigned to 94 residents during his shift. The facility QAPI program failed to ensure residents were provided care and services to meet a resident's highest practicable well-being for foot care and services causing pain for Resident #25 and #93. The facility QAPI program failed to provide oversight that established and implemented policies and procedures to ensure the facility provided effective housekeeping services and maintenance services to maintain a sanitary, orderly, and comfortable environment. These failures resulted in Immediate Jeopardy for Resident #5 #14, #25, #29, #30, #50, #72, #549, #550, and #551, actual Harm for Resident #25 and Resident #93, and Substandard Quality of Care in environment. 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 Director of Nursing (DON) were notified of the Immediate Jeopardy (IJ) for F-689 during the complaint investigation on 8/9/2022 at 6:20 PM, in the Omega Room. The Administrator and the Director of Nursing were notified of the Immediate Jeopardy (IJ) for F-600 and F-610 during the complaint investigation on 8/12/2022 at 2:50 PM, in the Omega Room. The Administrator and the Director of Nursing were notified of the Immediate Jeopardy (IJ) for F-609 and F-725 on 8/24/2022 at 7:03 PM, in the Omega Room. The [NAME] President of Clinical Operations, the Administrator, and the Director of Nursing were notified of the Immediate Jeopardy (IJ) for F-744, F-835, and F-867 on 8/26/2022 at 5:48 PM, in the Omega Room. (continued on next page)

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(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 - Many	The [NAME] President of Clinical Operations and the Regional Director of Clinical Operations were notified of the Immediate Jeopardy (IJ) for F-837 on 8/30/2022 at 12:04 PM, in the Omega Room. The facility was cited Immediate Jeopardy at F-600, F-609, F-610, F-689, F-725, F-744, F-835, F-837, and F-867. The facility was cited at F-600, F-609, F-610, and F744 at a scope and severity of K, at F-584 at a scope and severity of F, and at F-689 at a scope and severity of J, which is Substandard Quality of Care. The Immediate Jeopardy existed from 3/29/2022 and is ongoing. The findings include: (continued on next page)

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F 0867 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Review of the facility's undated policy titled Quality Assurance Performance Improvement Plan, revealed .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 program will be a coordinated effort among all department and services within the organization .The Quality Assurance and Performance Improvement committee will meet at a minimum on a monthly basis and as needed .The Quality Assurance and Performance Improvement Committee is set up to provide structure and direction for the Performance Improvement Program and Risk Management. The Quality Assurance and Performance Improvement Committee is responsible for establishing priorities, approving key quality indicators and assigning project team/s if deemed appropriate .Composition of the Performance Improvement Committee shall include but not limited to .Administrator .Director of Nursing . Medical Director .Nurse Practitioner .Consulting Pharmacist .Registered Dietitian .Medical Record .at least two other facility persons .RAI [Resident Assessment Instrument] Coordinator .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 .The following sources of data will be used .Resident electronic health record .Direct observation .Departmental logs .24-hour report .Clinical rounds check list .Accident/incident log/trending .Resident/family grievance log . PIP [Performance Improvement Project] committee minutes .Survey results .Compliance survey .ABAQIS [a complete quality management system] .Risk Management Reports .Safety Committee .QI/QM [Quality Indicators/Quality Measures] .The QAPI committee will review and coordinate all the proposed activities and identify the priorities .Once an aspect of care has been selected the committee .Decide if this is to be a concurrent or retrospective study .PIP will be established for the purpose of finding the root cause of the identified areas of concern .Identify the goal .These goals must be objective, measurable and based on current knowledge and/or clinical experience .It is expected that each department at any given time will generally be involved in one intensive Performance Improvement Project activity and one facility wide Quality Assurance Performance Improvement activity while continuing to perform routine monitoring at their respective areas .The department/committee will document findings, initiate corrective actions as directed and present results to the Quality Assurance Performance Improvement Committee .The Quality Assurance Performance Improvement committee will advise individual services and Performance Improvement Project Teams on methodology, data collection and data analysis and will review all final reports and recommendations .The goals, plans and results of the facility's Quality Assurance Performance Improvement activities will be communicated to all staff by means of staff meetings, changes in policy and procedures, and in-service training .The Quality assurance Performance Improvement Committee has the responsibility for designing and implementing corrective action plans as needed to resolve resident aspects of care/service problems. Improvement plans and effectiveness of actions will be documented in the committee minutes . (continued on next page)

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(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 - Many	Review of the undated Nursing Home 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 of care can be provided .As Administrator, you are delegated the administrative authority, responsibility and accountability necessary for carrying out your assigned duties .Serve on various committees of the facility .and provide written/oral reports of such committee meetings to the governing board as directed .Assist the Quality Assurance and Assessment Committee in developing and implementing appropriate plans of action to correct identified quality deficiencies . The facility's signed Director of Nursing job description dated 7/13/2021, 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 Medial Director, to ensure that the highest degree of quality care is maintained at all times .you are delegated that administrative authority, responsibility, and accountability necessary for carrying out your assigned duties .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 . During an interview on 8/26/2022 at 4:56 PM, the Administrator, DON, and [NAME] President of Clinical Operations confirmed the process of collecting data to bring to the QAPI to review would be anything that is under review. The [NAME] President of Clinical Operations stated, .we bring a spreadsheet, anything that is negative, we do a Root Cause Analysis . The Administrator, DON, and [NAME] President of Clinical Operations confirmed they look at the last survey results and stated, .working on elopement, we added a key-pad lock to restricted areas, wander guard system (a monitoring device to alert staff of a resident attempting to exit the facility unattended) .we identified the high-risk residents .new residents with the possibility of wandering .wander guards are placed on them .the doors were changed . The [NAME] President of Clinical Operations stated, .we changed elopement focus to unsafe areas, we had to look at our system processes. Qualitative and Quantitative measures in the facility behavior meeting, we go over the behavior meeting data, pharmacy reviews, Root Cause Analysis is brought to the behavior meeting . The DON confirmed behaviors are reviewed in QAPI once a month. The Administrator was asked if her Quality Assurance (QA) had been effective in the facility. The Administrator stated, for the most part, we have identified things that have been missed or are not adequate . The DON stated, .there was a lot y'all saw . The [NAME] President of Clinical Operations stated, .we have a tracking sheet now, it is more formal. The Administrator, Director of Nursing, and [NAME] President of Clinical Operations were asked how they monitor and ensure the facility and resident rooms are kept in good condition. The DON confirmed they do spot checks. The Administrator stated, .no designated time, it's random . (continued on next page)

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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 - Many	During a telephone interview on 8/30/2022 at 8:00 AM, the Chief Operating Officer (COO) confirmed the [NAME] President of Clinical Operations reported to her on the regular reports of QA, Patients at Risk (PAR), falls, weights and accidents. The COO confirmed she was not made aware of a resident exiting the building on 7/27/2022, and she confirmed it was a requirement that they notify her of any incident. She confirmed the facility determined the Root Cause Analysis for the first elopement was the resident did not have a wander guard on. She confirmed the facility determined the Root Cause Analysis for the second elopement was because the wander guard batteries were dead (the door the resident exited did not have a wander guard system). She confirmed she was not made aware of sexual abuse. She stated, It should have been reported, we have a procedure in place. Most oversite comes from policy and procedures. My oversite is to ensure the [NAME] President of Clinical Operations is trained and educated She confirmed she reviews the policies after they are written to make any needed changes. She confirmed she last attended a QA meeting before COVID (Coronavirus). The QAPI committee failed to ensure Administration developed and implemented policies and procedures, had a system in place to monitor nursing services and facility staff, and had a system to ensure allegations of abuse were thoroughly reported and investigated. Refer to F-600, F-609, F-610, and F-689 The QAPI committee failed to have a QAPI program that was ongoing, comprehensive, and addressed the full range of care and services provided by the facility and utilized the best available evidence to define and measure indicators of facility goals that reflected processes of care for residents with allegations of abuse. Refer to F-600, F-744, and F-835 The QAPI failed to establish, monitor, and implement policies and procedures to ensure adequate staffing. F-725 The QAPI committee failed to ensure behaviors were monitored. Refer to F-744 The QAPI committee failed to provide ongoing communication between the facility and the Governing Body, Administrative staff, including the Administrator, and the Director or Nursing to ensure identified concerns were addressed in a timely manner. Refer to F-837