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	10/13/2022

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 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34153 Based on policy review, review of the Director of Nursing (DON) job description, facility investigation review, medical record review, observation, and interview, the facility failed to complete a thorough investigation of an elopement incident for 1 of 6 (Resident #2) sampled residents reviewed for accidents and elopement risk, when Resident #2 exited the facility without staff knowledge or supervision. The facility failed to initiate a thorough investigation of a missing resident incident for 1 of 6 (Resident #1) sampled residents reviewed for accidents, when Resident #1 was missing for an undetermined amount of time and was found in a locked lobby bathroom of the facility. The facility's failure to thoroughly investigate incidents resulted in Immediate Jeopardy when the facility failed to thoroughly investigate the elopement of Resident #2 and the missing person of Resident #1. 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, Director of Nursing (DON) and the Clinical Operating Officer (COO) were notified of the Immediate Jeopardy for F-610 on 10/13/2022 at 5:10 PM. The facility was cited at F-610 at a scope and a severity of J which is Substandard Quality of Care. The Immediate Jeopardy existed from 9/13/2022 and is ongoing. The findings include: 1. Review of the facility's ELOPEMENT OF RESIDENT POLICY, reviewed 11/21/2021, revealed, .standard of this Health Care Center that appropriate procedures exist in the case of a missing resident .should an employee discover that a resident is missing .Determine time and location when last seen .Once the Resident is Located .the charge nurse will document the incident in the resident's medical record including times (time discovered, time of contacts) .The resident will be assessed by the M.D. [Medical Director] .The charge nurse will complete an Incident Report .The Administrator/Director of Nursing Services will notify the Department of Health .A complete and thorough root-cause analysis .should be done to prevent recurrences, to ensure policies, and procedures and systems are effective, and to protect other residents . (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 - Few	Review of the facility's policy titled, REPORTING OF ACCIDENT/INCIDENTS, reviewed November 2, 2021, revealed, .each incident involving a resident shall be documented on a standard Incident Report Form .All incidents are treated in the same manner .Accidents/Incidents will be investigated .Incidents are identified as any event or occurrence out of the ordinary .Incident Reports .Completed by the licensed nurse assigned to the resident .The nurse will complete a narrative notation in the medical record describing the accident/incident .The supervisor and nurse will initiate the investigation process and begin interviewing witnesses .interviews will be documented on the Witness Interview Form .Resident will be the first individual interviewed .interview as soon as possible after the incident .report shall be filed with specific state agency . investigation process for all incidents that require investigations .as soon as the following situations are identified .Resident left in a harmful or dangerous situation . Review of the facility's policy titled, ACCIDENTS AND INCIDENTS-INVESTIGATING AND REPORTING, reviewed November 2021, revealed, .All accidents and incidents involving residents .occurring on our premises shall be investigated .The Nurse Supervisor/Charge Nurse and/or the department director or supervisor shall promptly initiate and document investigation of the accident or incident .The following .shall be included on the Report of Incident/Accident form .the date and time the accident or incident took place . Review of the facility's UNSAFE WANDERING-ELOPEMENT RISK POLICY, reviewed November 25, 2021, revealed, .every effort will be made to prevent unsafe wandering episodes while maintaining the least restrictive environment for residents .should an elopement episode occur, an incident report will be completed providing explanation of how the event occurred and contributing factors . Review of the facility's signed (Interim) Director of Nursing job description dated 9/7/2022, 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 . 2. Review of the medical record revealed Resident #2 was admitted to the facility on [DATE] with diagnoses of Dementia, Hypertension, Anxiety, Major Depressive Disorder, Insomnia, Lack of Coordination and Unsteadiness on Feet. Review of the care plan dated 7/27/2022, revealed Resident #2 was an elopement risk/wanderer with a history of attempts to leave the facility. Review of a physician order dated 8/31/2022 revealed, Wander guard due to behaviors exhibiting elopement. Check placement of Wander guard every shift, if not intact replace. Review of the quarterly Minimum Data Set (MDS) dated [DATE], revealed Resident #2 was assessed with a Brief Interview for Mental Status (BIMS) score of 4, indicating she was severely cognitively impaired, required limited assessment to extensive assistance with ADLs, always incontinent of bowel and bladder and uses wheelchair for mobility. (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 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the facility's timeline summary and investigation revealed, .10/2/2022 at 4:43 pm Resident #2 was sitting at front lobby screening table with Resident #6 (wander, elopement risk, wander guard resident) unsupervised and not monitored .Resident #2 stands up at the front door entry exit and begins rocking and attempting to force the door nearest to the temperature machine open .Resident #2 exits the facility front/exit door and walks directly to the security officer's gray pick-up truck and sits in the passenger side of the truck. The Security Guard leaves Resident #2 in the truck unsupervised to go into building to get assistance. Review of the Elopement Evaluation dated 10/2/2022, revealed Resident #2 was assessed at a score of 3 indicating at risk for elopement. Resident #2 exhibits wandering behavior and utilizes an exit alarm (wander guard). Review of the revised care plan dated for Resident #2 dated 10/2/2022 revealed, resident one (1) on one (1) at this time, monitor location every shift, maintain wander guard bracelet per physician's orders and check placement every shift. There was missing documentation after 10/2/2022 that the wander guard bracelet was intact. During a telephone interview on 10/5/2022 at 4:15 PM, CNA #3 (agency staff) stated they had worked a double shift the day that Resident #2 eloped. CNA #3 stated when they exited the front door to go on break that Resident #2 was sitting near the front entrance door. CNA #3 stated when they came back to the facility from across the street the facility staff was at the security guard's truck taking Resident #2 back into the facility. CNA #3 stated, .I knew she [Resident #2] was a wanderer .I told the nurse earlier that day [Resident #2's] wander guard bracelet was on the wheelchair .the nurse looked at me as if I didn't need to say anything and the nurse didn't do anything about it . During an interview on 10/5/2022 at 4:15 PM revealed the Interim Administrator stated she reviewed the video footage for Resident #2's elopement but stated she did not save the video as part of an investigation. The Interim Administrator provided the survey team with a documented timeline based on her recollection of the video. The facility was unable to provide the team with video footage of the incident. During an interview on 10/5/2022 at 4:55 PM, the Security Guard stated, .she [Resident #2] was pushing on the entrance door to get out, the door opened, and came to the truck and said I want you to take me home . she got in the truck, put the seat belt on and I locked the truck .the front windows were down .told her I was going to tell the nurses I was going to take her home .went in the building to get assistance and they came and got her . During an interview on 10/6/22 at 3:19 PM, the Interim Administrator stated, .she got up from the wheelchair . pushed on the door and it opened .went straight to the security guard's truck that was parked at the front entrance . security guard secured her in the truck with the seat belt .security guard came in the building about 3-minutes .he returned to the truck .3 staff came out and brought the resident back in .she was not unsupervised because he was with her . The Interim Administrator was asked if the security guard a facility staff member. The Interim Administrator stated, .no, he is contracted .no, he is not our staff . The Interim Administrator confirmed Resident #2 was unsupervised while the security guard went into the building to get assistance. The Interim Administrator stated .yes .but it was only a few minutes . The Interim Administrator confirmed Resident #2 was sitting in the lobby unsupervised and staff was unaware. (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The Interim Administrator confirmed when Resident #2 exited the building and .no staff was in the lobby .and staff did not take [Resident #2] back to her room .no .this is their home and it's their right to sit in the lobby and watch TV . The Interim Administrator was asked should wandering elopement risk residents wearing wander guards be sitting in the lobby unsupervised and without staff. The Interim Administrator did not answer. During a telephone interview on 10/7/2022 at 1:30 PM, CNA #4 stated .I am agency staff .have only worked at facility a few times . I checked my room assignment and [Resident #2] was not in the bed or room .I assumed she was gone to the hospital .did not see [Resident #2] until she was being escorted to her room . the nurse informed me that was [Resident #2] was my resident. I took her in her room and to the bathroom, it was around supper time .I did not provide 1 to 1 observation after the incident. I did not provide 15-30 minutes checks for [Resident #2] .no one told me to do any safety checks .I did not write a statement, and none has called me from the facility about writing a statement . 3. Review of the medical record revealed Resident #1 was admitted to the facility on [DATE] with diagnoses of Schizophrenia, Dementia, Traumatic Brain Injury, and Anxiety. Review of the care plan revised 6/22/2022, revealed Resident #1 had an Activities of Daily Living (ADL) self-care performance deficit that required cues, encouragement, and supervision related to Dementia and delusions. The interventions included supervision/assistance with all decision making. Resident #1 had impaired cognitive function and impaired thought processes related to dementia. Communication problem related to head injury, is usually understood, usually understands, and had delusions. Interventions included ensure/provide a safe environment avoid isolation. Review of a BIMS assessment completed on 8/22/2022, revealed Resident #1 was assessed with a BIMS of 4 indicating severe cognitive impairment for daily decision making. Review of the quarterly MDS mental assessment dated [DATE], revealed Resident #1 had modified independence with difficulty in a new situation. Resident #1 was independent for dressing, requires supervision for locomotion on and off the unit, eating and personal hygiene. Resident #1 required extensive one person assistance for bed mobility, transfer, and toilet use. Resident #1 was occasionally incontinent of urine and frequently incontinent of bowel. Review of an elopement risk assessment dated [DATE] revealed Resident #1 was not assessed at risk for elopement. Review of a nurse's progress note marked as Draft and dated 9/14/2022 documented, .1220 [AM] during 1st round staff was alert [alerted] by CNA [Certified Nurse Assistant], Resident was not in her bed or bathroom. Staff directed to look for resident while this nurse searched [NAME] 1 [unit] after 5-10 minutes of direct searching Dr. Find [emergency code called for a missing resident] was call overhead AT 12:20 [AM], Staff continued to search. Approx. [approximately] 5 min [minutes] after Dr. Find was announced, Resident was located by [Licensed Practical Nurse (LPN) #1] in the employee bathroom in the Front Lobby @ [at] 12:30 [AM] .with noted confusion . (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of a Psychiatric Nurse Practitioner progress note dated 9/15/2022 revealed, .asked to see ahead of scheduled visit due to new problem. Staff reports she wandered off unit .could not be found for some time . found .in employee bathroom .says she went in to use the bathroom and could not get the door open .3 [NAME] Carters locked me in .poor grip on reality and incorporates delusional fantasy world into everyday interactions .delusional ideas are expressed .reasoning is illogical .associations are loose .insight into problems appears to be poor . During an Allegation of Compliance (AoC) validation revisit on 9/16/2022 to remove Immediate Jeopardy from the previous 8/30/2022 recertification survey an entrance conference interview was conducted with the Interim Administrator. On 9/16/2022 at 9:30 AM, the Interim Administrator was asked if there were any elopements, Dr. Find for missing residents, or any incidents since the exit on 8/30/2022. The Interim Administrator stated, .no . During an interview on 9/28/2022 at 12:40 PM, the Interim Administrator, the Interim DON and DON was asked if there had been any incidents of a missing resident, or any incidents of a resident being found in a bathroom? The Interim Administrator stated, .no . The DON stated, .a resident was found in the [employee/lobby bathroom] .wasn't gone but 5 or 10 minutes . During an interview on 9/28/2022 at 1:15 PM, the Interim Administrator stated, .I talked to the nurse [Licensed Practical Nurse (LPN) #2] on the phone that night [night the resident was missing], she said during the 1st round staff identified she was not in her room . The Interim Administrator was asked how long had she been gone from her room? The Interim Administrator stated, .I assumed LPN #2 had seen her that night at shift change [11pm] .the staff called a Dr Find .did what they were supposed to do .I didn't have a reason to start an investigation .she wasn't gone that long, she was found in the bathroom .I don't have any interviews . The Interim Administrator was asked do you know how long she was missing and how long she was in the lobby bathroom? The Interim Administrator stated, .no . During a telephone interview on 9/29/2022 at 2:58 PM housekeeping staff #1 stated, .got to work about 9:00 PM .we were stripping and waxing the floors in the area around the restrooms [across from dining room] . tried to get into the women's bathroom to do the floor but the door was locked .knocked but there wasn't an answer .tried several times .about 12 or so the staff said a resident was missing .my supervisor told them to check that bathroom .the resident was in there and they brought her out .I was not asked to write a statement about this and no one has called me for an interview . During a telephone interview on 10/3/2022 at 9:01 AM, LPN #1 stated, .[Resident #1] missing about 2-3 weeks ago .they paged a Dr Find .I started looking .I went up the hall toward the lobby .I knocked on the [lobby/employee] bathroom door, no one said anything, I checked the door, it was locked .I used a credit card to unlock the door, I opened the door and she was standing in the bathroom .I didn't know how long she had been there .I don't know if it was hard for her to pull the door open .did not write a statement .wasn't interviewed about it . (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 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During a telephone interview on 10/5/2022 at 3:30 PM, CNA #2 stated, .I worked a double that day I was assigned rooms down from her [Resident #1] .hadn't see her that night walking in the hall .noticed the tray [supper] was still in the room and hadn't been touched .they checked to see if she was out to the hospital or signed out .called the Dr. Find code and everyone started looking for her .I looked around on the hall .I think a nurse found her .she [Resident #1] was pretty shook up she said she [Resident #1] was on the floor, she said water was coming in so she [Resident #1] put paper towels down on the floor, she [Resident #1] said she heard a man say he didn't have a key she [Resident #1] said she was in there for a while .the lobby bathroom door had been locked that night .unusual for her to be up .she's always in her room .she was pretty shook up she didn't want to be alone, I ended up sitting with her that night .she finally went to sleep .I did not write a statement . During an interview on 10/7/2022 at 10:37 AM, LPN #3 Unit Manager (UM) confirmed she was aware of a Dr Find code being called to find Resident #1 who was missing. LPN #3 UM stated, .discussed it in the morning meeting didn't consider it an incident .did not investigate . [Resident #1] refused to put on the wander guard . she said it was a tracking device .refused the UA [urinalysis] .and there was not a sitter with her that morning when I came to work .and was not monitored . During an interview on 10/7/2022 at 1:51 PM, with the Director of Nursing ((DON) previously the Assistant Director of Nursing) stated we talked about it [Resident #1] they were looking for her and they had called a Dr Find .[LPN #2] had told the [LPN #3 UM] what had happened .that she [Resident #1] had went to the [lobby] bathroom .under normal circumstances she could open the door .the Psychiatric Nurse Practitioner said something else was going on with her .uncertain if she could use the call light in that bathroom . The DON was asked when is a Dr Find code utilized and how often is it used to find residents? The DON stated, . is called after 15 minutes of looking for a resident .I did not think it was a true Dr Find . because of the time of what was reported . The facility was unable to provide documentation that an investigation was conducted for the incident of Resident #1, a vulnerable resident with a history of delusional thinking, Schizophrenia and bizarre thoughts, being found in a locked bathroom for an undetermined amount of time. The facility failed to determine the last time Resident #1 was seen in the facility prior to the resident becoming missing and failed to ensure Resident #1 was provided care in a safe environment.

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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 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** 34153 Based on policy review, facility investigation review, Quality Assurance and Performance Improvement (QAPI) Root Cause Analysis (RCA) Worksheet review, Life Safety Code, medical record review, observation, and interview, the facility failed to ensure appropriate supervision and a safe environment to prevent an incident of elopement for 1 of 5 (Resident #2) sampled residents reviewed for elopement and wandering behaviors. The facility failed to provide adequate supervision for a safe environment to prevent a missing resident incidents for 1 of 6 (Resident #1) sampled residents reviewed for incidents. The facility failed to ensure a safe environment that had the potential to affect all staff and all residents by re-programming the front entrance/exit door emergency delay egress (door exit bar) from 15 seconds to 50 seconds. The facility's failure to ensure a safe environment to prevent elopements resulted in Immediate Jeopardy (IJ) when Resident #2 a vulnerable cognitively impaired resident at risk for elopement and wandering was left unsupervised in the front lobby, exited the facility without authorization or staff supervision through the facility's front door. Resident #2 was discovered approximately 44 feet from the front door, sitting in a security guard truck. The facility's staff was unaware Resident #2 had exited the building until a security guard went back into the building to notify the staff, leaving Resident #2 in the truck unattended and unsupervised. Resident #2 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 by applying pressure to the front entrance/exit door until it opened. The facility's failure to ensure appropriate supervision and a safe environment resulted in Immediate Jeopardy (IJ) when Resident #1, a vulnerable cognitively impaired resident was missing for an undetermined amount of time and was later found in a locked lobby bathroom. The facility's failure to ensure a safe environment resulted in Immediate Jeopardy (IJ) when the front entrance/exit door push pressure emergency opening was reprogrammed from the approved 15 seconds to an unapproved 50 seconds, this had the potential to affect all staff and residents. Reprograming a delayed release (door exit bar) from greater than 30 seconds without prior approval is a violation of Life Safety Codes National Fire Protection Association (NFPA)101, 19.2.2.2.4 (2) 2012 Edition and NFPA 101, 7.2.1.6.1.1 (3) 2012 Edition. 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, Director of Nursing (DON) and Chief Operating Officer (COO) were notified of the Immediate Jeopardy on 10/13/2022 at 5:10 PM. The facility was cited Immediate Jeopardy at F-689. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The facility was cited F-689 at a scope and severity of J which is Substandard Quality of Care. The IJ existed 9/13/2022 and is ongoing. The findings include: 1. 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 the facility's policy titled, ELOPEMENT OF RESIDENT POLICY, dated August 2017, revealed .It is standard of this Health Care center that appropriate procedures exists in the case of a missing resident . Determine time and location when last seen .The Charge Nurse will complete an Incident report .the Administrator /director of Nurses Services will notify the Department of Health per State Regulations .If an elopement occurs, a monitoring schedule will be implemented to ensure resident's safety . Review of the facility's policy titled, Alarms Policy, dated September 1, 2018, revealed, .An alarm is any physical device or electronic device that monitors resident movement and alerts the staff by either audible or inaudible means, when movement is detected and may include .door alarms, or elopement/wandering devices .alarms do not replace necessary supervision .Wander/Elopement alarms include such devices as bracelets .building/unit exit sensors worn or attached to the resident that alert the staff when the resident nears or exits the building . Review of the facility's policy titled, ACCIDENTS AND INCIDENTS-INVESTIGATING AND REPORTING, reviewed/revised November 2021, revealed, .All accidents and incidents involving residents .occurring on our premises shall be investigated .The Nurse Supervisor/Charge Nurse and/or the department director or supervisor shall promptly initiate and document investigation of the accident or incident .The following .shall be included on the Report of Incident/Accident form .the date and time the accident or incident took place . Review of the facility's UNSAFE WANDERING-ELOPEMENT RISK POLICY, reviewed November 25, 2021, revealed .every effort will be made to prevent unsafe wandering episodes .should an elopement episode occur, an incident report will be completed providing explanation of how the event occurred and contributing factors . Review of the Life Safety Codes NFPA 101, 19.2.2.2.4 (2) (2012 Edition), NFPA 101, 7.2.1.6.1.1 (3) (2012 Edition) documented an irreversible process shall release the lock in the direction of egress within 15 seconds or 30 seconds where approved by the authority having jurisdiction. 2. Review of the medical record revealed Resident #2 was admitted to the facility on [DATE] with diagnoses of Dementia, Hypertension, Anxiety, Major Depressive Disorder, Insomnia, Lack of Coordination and Unsteadiness on Feet. (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 care plan dated 7/27/2022, revealed Resident #2 is an elopement risk/wanderer with a history of attempts to leave the facility unattended, impaired safety awareness with the updated intervention on 10/2/2022 (after the resident eloped), one (1) on one (1) at this time, monitor location every shift, maintain wander guard bracelet per MD (Medical Doctor) orders, and check wander guard placement every shift. Review of a Physician's order dated 8/31/2022 revealed, wander guard due to exhibiting elopement behaviors, check placement of wander guard every shift, if not intact replace, and document in progress note every shift. Review of the Minimum Data Set (MDS) dated [DATE], revealed Resident #2 was assessed with a Brief Interview for Mental Status (BIMS) score of 4, indicating she was severely cognitively impaired, required limited assessment to extensive assistance with ADL's, always incontinent of bowel and bladder and uses wheelchair for mobility. Review of the Elopement Evaluation dated 10/2/2022, revealed risk for elopement score of 3, which indicated Resident #2 exhibits wandering behavior, has a pattern, and is goal directed, utilizes exit alarm (wander guard). Review of a Nurses Notes dated 10/2/2022 documented .Resident being observed being escorted to room . resident was found outside in the security guard's truck .resident walked to the security's guard truck and ask for a ride home .security guard reported he had resident sitting in front seat of truck . Review of the facility's timeline summary and investigation dated 10/2/2022 revealed, .10/2/2022 .[Resident #2] sitting at front lobby screening table with [Resident #6] .[Resident #2] rolls wheelchair to front lobby entry/exit .stands up at the front door entry exit and begins rocking and attempting to force the door nearest to the temperature machine open .5:12pm [Resident #2] exits the facility front/exit door and walks directly to the security officer's gray pick-up truck and sits in the passenger side of the truck .5:16 Security Guard enters facility using keypad to enter code for door access to alert staff for assistance .5:19pm [Resident #2] is escorted back in facility with staff .6:00pm Maintenance Director notified .8:17pm Maintenance Director Notified the Administrator that all doors/wander guards are working properly .10/3/2022 at 11:00am-Administrator and Maintenance Director (programed) 15 second release function was changed to 50 second release function (exit bar) . Review of the QAPI Root cause analysis dated 10/3/2022 revealed, .Root Cause Analysis .Why .doors automatically open after 15seconds of push pressure .Why resident BIMS 4, elopement risk and even though cognitive impairment resident was able to push on door to open .instructions to Coaches .elopement and wandering procedures for identifying, reporting and interventions . Observation on 10/6/22 at 4:17 PM revealed, the Maintenance Director and surveyor measured distance from the door threshold to the passenger side of the security guards' truck passenger side was 44 feet. The distance from the passenger side of the truck to a street by the facility, a busy and highly traveled street, measured 75 feet. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445387	A. Building B. Wing	10/13/2022

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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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an telephone interview on 10/5/2022 at 4:15 PM, CNA #3 stated, .I am agency staff and I worked a double that day .I left to go on break .[Resident #2] was sitting at the front entrance near the entrance door beside where they take temperatures .I went out the door she was still sitting there .when I came back from across the street staff was outside at the security guard's truck taking her back in the facility .I have worked with her before .I knew she was a wanderer .I told the nurse earlier that day [Resident #2's] wander guard bracelet was on the wheelchair .the nurse looked at me as if I didn't need to say anything and the nurse didn't do anything about it . During an interview on 10/5/2022 at 4:55 PM, the Security Guard stated, .she [Resident #2] was pushing on the entrance door to get out, the door opened, and came to the truck and said I want you to take me home. I told her to hop in .she got in the truck, put the seat belt on and I locked the truck .the front windows were down .told her I was going to tell the nurses I was going to take her home .went in the building to get assistance and they came and got her . During an interview on 10/6/22 at 3:19 PM, the Interim Administrator stated, .she got up from the wheelchair . pushed on the door and it opened .went straight to the security guard's truck that was parked at the front entrance .got in on the passenger side .security guard secured her in the truck with the seat belt .security guard came in the building about 3-minutes .he [Security Guard] returned to the truck .3 staff came out and brought the resident back in .she was not unsupervised because he was with her . The Interim Administrator was asked if the security guard a facility staff member. The Interim Administrator stated, .no, he is contracted .no, he is not our staff . The Interim Administrator confirmed Resident #2 was unsupervised while the security guard went into the building to get assistance. The Interim Administrator stated .yes .but it was only a few minutes . The Interim Administrator confirmed Resident #2 was sitting in the lobby unsupervised and staff were unaware. The Interim Administrator confirmed Resident #6 (at risk for wandering, elopement, and had a wander guard) was in the lobby unsupervised and staff were unaware. The Interim Administrator stated, . yes, the other resident [Resident #6] sitting in the lobby near the receptionist window, then she left the area leaving [Resident #2] sitting by the temperature stand at the table near the front entrance door .no staff was in the lobby . The Interim Administrator was asked if facility staff were aware that Resident #2 and Resident #6 were at risk for wandering, elopement and had a wander guard. The Interim Administrator stated, .yes, and staff did not take [Resident #2] back to her room .no .this is their home and it's their right to sit in the lobby and watch TV . The Interim Administrator was asked should 2 wandering elopement risk residents wearing wander guards be sitting in the lobby unsupervised and without staff. The Interim Administrator did not answer. During a telephone interview on 10/7/2022 at 1:30 PM, CNA #4 stated .I am agency staff .have only worked at facility a few times .My assignment was changed an hour and half into the shift .did not get report from anyone .I checked my room assignment and [Resident #2] was not in the bed or room .I assumed she was gone to the hospital .did not see [Resident #2] until she was being escorted to her room .the nurse informed me that was [Resident #2] was my resident. I took her in her room and to the bathroom, it was around supper time .Did not get any orientation or information about [Resident #2] or any other residents being wanderers .I did not provide 1 to 1 observation after the incident. I did not provide 15-30 minutes checks for [Resident #2] . I checked on during my rounds that night but not 15-30-minute checks .no one told me to do any safety checks .I left when shift ended .I did not write a statement, and none has called me from the facility about writing a statement . (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 10/5/2022 at 4:15 PM revealed the Interim Administrator stated she reviewed the video footage for Resident #2's elopement but stated she did not save the video as part of an investigation. The Interim Administrator provided the survey team with a documented timeline based on her recollection of the video. The facility was unable to provide the team with video footage of the incident. During the exit conference on 10/13/2022 beginning at 5:10 PM, The COO (who was present via telephone) stated .It was reported to me that the wander guard door monitor on the door was malfunctioning .the delayed egress was changed from 15 seconds to 50 seconds . The facility failed to conduct a thorough investigation that identified the root cause(s) for Resident #2's elopement, failed to preserve sources of information obtained, and failed to implement interventions to provide a safe and secure environment for all residents. The facility failed to ensure facility staff and contract agency staff were knowledgeable of the residents' needs and could demonstrate the monitoring and supervision required for wandering residents with an elopement risk. 3. Review of the medical record revealed Resident #1 was admitted to the facility on [DATE] with diagnoses of Schizophrenia, Dementia, Traumatic Brain Injury, and Anxiety. Review of the care plan revised 6/22/2022, revealed Resident #1 has an Activities of Daily Living (ADL) self-care performance deficit that requires cues, encouragement, and supervision related to Dementia and delusions. The interventions included supervision/assistance with all decision making. Resident #1 has impaired cognitive function and impaired thought processes related to dementia. Resident #1 had communication problems related to a head injury and is usually understood, usually understands, and has delusions. Interventions included ensure/provide a safe environment avoid isolation. Review of a BIMS assessment completed on 8/22/2022, revealed Resident #1 was assessed with a BIMS of 4 indicating severe cognitive impairment for daily decision making. Review of the quarterly MDS dated [DATE], revealed a staff assessment of mental status Resident #1 had modified independence with difficulty in new situation. Resident #1 was independent for dressing, requires supervision for locomotion on and off the unit, eating and personal hygiene. Resident #1 required extensive one person assistance for bed mobility, transfer, and toilet use. Resident #1 was occasionally incontinent of urine and frequently incontinent of bowel. Review of the nurses progress note Draft dated 9/14/2022 documented, .1220 [AM] during 1st round staff was alert by CNA [Certified Nurse Assistant], Resident was not in her bed or bathroom. Staff directed to look for resident while this nurse searched [NAME] 1 [unit] after 5-10 minutes of direct searching Dr. Find [emergency code called for a missing resident] was call overhead AT 12:20 [AM], Staff continued to search. Approx. [approximately] 5 min [minutes] after Dr. Find was announced, Resident was located by [Licensed Practical Nurse (LPN) #1] in the employee bathroom in the Front Lobby @ [at] 12:30 [AM] .with noted confusion . Review of an elopement risk assessment dated [DATE] revealed Resident #1 was not assessed at risk for elopement. (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 a Psychiatric Nurse Practitioner progress note dated 9/15/2022 revealed, .asked to see ahead of scheduled visit due to new problem. Staff reports she wandered off unit .could not be found for some time . found .in employee bathroom .says she went in to use the bathroom and could not get the door open .3 [NAME] Carters locked me in .poor grip on reality and incorporates delusional fantasy world into everyday interactions .delusional ideas are expressed .reasoning is illogical .associations are loose .insight into problems appears to be poor . Observation on 9/28/2022 at 10:54 AM revealed, the lobby bathroom door is unlocked, a call light is located on the wall to the right of the toilet, the bathroom door has lever with a push button lock on the inside of the bathroom. Observation on 10/4/2022 at 4:59 PM, the lobby bathroom door is locked, appears to be a new lever handle on the door, a key is hanging on the door approximately 6 feet to the right of the door with sign below the key with instructions to use key to enter the bathroom. On the inside of the bathroom another sign instructing to return the key to the hook outside the door. Call light noted on the wall beside commode. Observation on 10/06/2022 at 12:33 PM, revealed the front entrance exit door did not open or alarm when constant pressure was applied for over 60 seconds. Observation on 10/6/2022 at 4:09 PM, revealed one side of front entrance exit door did not open or alarm when constant pressure was applied for over 50 seconds. The observation was verified by the Maintenance Director and the Administrator. During an Allegation of Compliance (AoC) validation revisit on 9/16/2022 to remove Immediate Jeopardy from the previous 8/30/2022 recertification survey an entrance conference interview was conducted with the Interim Administrator. On 9/16/2022 at 9:30 AM, The Interim Administrator was asked if there were any elopements, Dr. Find for missing resident, or any incidents since the exit on 8/30/2022. The Interim Administrator stated, .no . During an interview on 10/6/2022 at 3:19 PM, the [Interim] Administrator and Maintenance Director was asked if the front exit entry door push pressure emergency opening was reprogrammed from 15 seconds to 50 seconds. The [Interim]Administrator stated, .that was a typo .can I change that . The Maintenance Director stated, .no .it was not changed . During an interview on 10/6/2022 at 4:17 PM, the Maintenance Director confirmed the front exit entry door push pressure emergency opening was reprogrammed from 15 seconds to 50 seconds. During a telephone interview on 9/29/2022 at 10:03 AM, CNA #5 stated, .I don't remember anything about that resident or her being missing. CNA #5 was asked if she was Resident #1's CNA that night. CNA #5 stated, .yes, I worked 3p-11p that night . During a telephone interview on 9/29/2022 at 10:23 AM, LPN #4 stated, .I was at the med cart the aide [CNA #1] came and asked if we knew where [Resident #1] was .Resident #1's dinner tray was in the room and hadn't been touched .everyone looked around on the unit for about 5 minutes .called a Dr. Find (code for a missing resident) looked about 5-10 more minutes .[LPN #1] found her in the employee bathroom up front [by dining room] .since her tray wasn't touched we didn't know how long she'd been gone .she normally eats . she said herself she was gone a while . (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During a telephone interview on 9/29/2022 at 2:09 PM the housekeeping supervisor, stated, .yes I was working came in around 8 pm that night to strip the floors .ladies bathroom [lobby] was locked, it's normally unlocked .after shift change (11:00 PM shift change) staff was looking for a resident .I told them the bathroom door .had been locked for a while told them to check in there .I didn't see anyone going in and out of the bathroom .I had checked it several times that evening and it was locked .knocked but no one would answer .saw the staff looking for someone .they went in the bathroom a female resident was in there .I was not interviewed about it until you called today . During a telephone interview on 9/29/2022 at 2:58 PM, housekeeping staff #1 stated, .got to work about 9:00 PM .we were stripping and waxing the floors in the area around the restrooms [across from dining room] . tried to get into the women's bathroom to do the floor but the door was locked .knocked but there wasn't an answer .tried several times .about 12 or so the staff said a resident was missing .my supervisor told them to check that bathroom .the resident was in there and they brought her out . During a telephone interview on 9/29/2022 at 4:00 PM, housekeeping staff #2 stated, .yes worked the night they were looking for a resident .told them to look in the ladies bathroom (by the dining room) .it had been locked a while .she [Resident #1] was in there they brought her out . During a telephone on 9/30/2022 at 3:38 PM, LPN #2 stated, .in her bed asleep or in the bathroom in her room .I can't say for sure how long she was gone .the aide [CNA#1] went to her room between 11:30 PM and 12 AM, she came and asked me if I knew where [Resident #1] was .I looked in the computer to see if she was out .started looking .didn't find her .called a missing person code [Dr. Find] so everyone could look . she was in the bathroom by the dining room .found her about 15 minutes after the aide [CNA #1] asked where she was .[Resident #1] had some noted confusion .said people were knocking on the door .she thought [NAME] had sent someone to get her .I think she was scared to come out because of the floor machines running .[LPN #1] found her in the bathroom .scared to come out because of the machines and the people knocking on the door .she stays in her room .I talked to the [Interim] Administrator and [Interim] DON that night about it . During a telephone interview on 9/30/2022 at 9:31 PM, CNA #1 stated, .I worked that night .it was close to midnight [Resident #1] wasn't in her room .her meal tray [supper] had not been touched .silverware not opened or anything .I told LPN #2 she was not in her room .they called a Dr Find .she was found in the bathroom across from the dining room laying on the floor in the dark .she was scared .she'd been gone since before supper .the noise from the buffer scared her .I hadn't seen [Resident#1] since I come on shift at 11pm .they brought her out of the bathroom .her dinner was served around 5 or so she didn't eat .[Resident #1] told me she was in there a long time .said she went for a walk before supper .had to use the bathroom she said it was about 4:30 pm. I asked her how she knew what time it was, and she said because she looked at the clock .I walked her to her room and when we went in the room she started crying and said you see [looking at her meal tray] that's how long I was gone. She was upset . I did not write a statement and I was not interviewed about this incident .Resident #1 mostly eat her meals in her room . (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 telephone interview on 10/3/2022 at 9:01 AM, LPN #1 stated, .paged Dr. Find .looking for the resident .went up the hall toward the lobby .I knocked on the [lobby bathroom] door, no one said anything the door was locked .I used a credit card to pop the lock on the door .I opened the door and she was standing in the bathroom .I don't know if she went in there and it was hard for her to pull the door open .there were floor techs doing the floors that night .I think they mentioned after she was found that the door had been locked for a while .no I did not write a statement and I was not interviewed .Resident #1 is pleasantly confused . During an telephone interview on 10/3/2022 at 10:07 AM, the Psych Nurse Practitioner (NP) stated, .[Resident #1] refuses medications and is very guarded .I saw her that Thursday [9/15/2022] .the staff didn't say how long she was gone .just that they looked for a while .[Resident #1] has no grip on reality .incorporates things seen on tv into her life .she told me her daughter was married to the prince of England .she told me she went to the bathroom and couldn't open the door said that 3 [NAME] Carters locked her in . During an interview 10/4/2022 at 5:25 PM, Resident #1 stated, .I've got a good appetite .my sons do not visit much they're really busy .my sons are doctors .I've been here 4 months .I'm not supposed to be here .if I'm not out of here tonight .if I can't drive, I'll talk to you tomorrow . During an interview on 10/5/2022 at 10:45 AM, CNA #6 stated, .Resident #1 is always confused very paranoid when it comes to noise and loud sounds .confused not very oriented .she eats in her room .I don't think she would put it together to unlock the door or to use the call light in the [lobby] bathroom, it's a different call light than the one in her room . During a telephone interview on 10/5/2022 at 3:40 PM, CNA #2 stated, .I worked a double (3p-11p and 11p-7a) that day .I ended up sitting with her that night .I hadn't seen her during the shift .she was pretty shook up she said she was on the floor, she [Resident #1] said water coming in so she [Resident #1] put paper towels down on the floor she said she heard a man say he didn't have a key .I tried to use that bathroom [lobby] that night several times and the door was locked .unusual for her [Resident #1] to be up that late .she's always in her room .she [Resident #1] was pretty shook up she didn't want to be alone .she [Resident #1] said she was in there for a while . During an interview on 10/6/2022 at 2:25 PM, LPN #4 stated, .we were about to go outside and start looking for [Resident #1], when we were walking up the hall to go outside, we met [LPN #1] and [Resident #1] .the [CNA #5] that was assigned [Resident #1] on the 3P-11P shift was already left .[Resident #1] was scared, frantic, and didn't want to be alone in her room .I would think this was an incident .it's a different call light than what is in her room, not sure she would know how to use it .she [Resident #1] said she heard people knocking .they had tried to get in the bathroom door but the door was locked .she said I've been gone so long I didn't get my meal and I'm hungry .so hungry she ate her meal cold .I feel like it was an elopement . During an interview on 10/6/2022 at 6:05 PM, LPN #5 stated, .not sure she would use the call light in that bathroom .she [Resident #1] doesn't like loud noises because when her roommate makes noise she comes to the desk and tells us .doesn't ever use the call light in her room . she comes out and comes to the desk .I was not asked and did not write a statement . (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 10/7/2022 at 10:37AM, LPN #3 stated, .when I came in [LPN #2] told me about the Dr. Find code on her shift .discussed in the morning meeting .[Interim] Administrator wasn't in the meeting .I can't remember if any statement were given to me .this didn't meet the criteria for an incident .she refused the UA [urinalysis] .she refused to put on the wander guard because she said she went to the bathroom and it [wander guard] was a tracking device .went by what was in the nurse note .no monitoring other than looking in on her . During an interview on 10/7/2022 at 1:51 PM, the DON (ADON at the time of incident) stated, .[Resident #1] walks from her room to the dining room .that morning in the clinical meeting someone said they were looking for her and called a Dr. Find Code .the Psych NP [Nurse Practitioner] said something else was going on with her [Resident #1] .a Dr. Find code is called after 15 minutes of looking for them .I did not think it was a true Dr. Find .we do not use a Dr. Find Code often to find residents . During an telephone interview on 10/10/2022 at 9:35 AM, LPN #2 stated, .Resident #1 was fully dressed the night she was found in the bathroom .she had a sitter that night to keep an eye on her .[LPN #1] said she was standing in the bathroom when she opened the door .the door was locked on the inside she had to use a credit card to get into the bathroom .I hadn't seen her since I came in that night .she was having delusions that [NAME] or [NAME] had sent their men to get her because someone kept knocking on the door and those floor machines were running . in the state of mind she was in I don't think she knew how to use the call light in the [lobby] bathroom . The facility staff failed to monitor and provide proper supervision to ensure a resident with known delusional and paranoid behavior was in safe environment. The facility failed to monitor and ensure a safe environment free of accident hazards for a vulnerable cognitively impaired resident with delusions and paranoid behaviors.

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Administer the facility in a manner that enables it to use its resources effectively and efficiently. 34153 Based on policy review, job description review, Quality Assurance Performance Improvement (QAPI) Root Cause Analysis (RCA) Worksheet, 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 for incidents 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 a safe and secure environment when Resident #2 a exited the facility unsupervised and without staff knowledge, got in the security guard's vehicle, and was left unsupervised in the vehicle while the security guard entered the facility to notify facility staff. The facility failed to conduct a thorough investigation of incidents and obtain statements from all direct care staff. Administration failed to ensure an incident report was completed when Resident #2 exited the facility unsupervised and without staff knowledge. Administration failed to investigate an incident of Resident #1 a confused, vulnerable resident that was found in a locked lobby bathroom for an undetermined amount of time. These failures resulted in Immediate Jeopardy for Resident #2 and Resident #1. The Administration's failure to ensure a safe environment resulted in Immediate Jeopardy (IJ) when the front entrance/exit door push pressure emergency opening was reprogrammed from 15 seconds to 50 seconds, having the potential to affect all residents and facility staff. Reprograming the emergency delayed release (door exit bar) greater than 30 seconds without prior authorization is in violation of Life Safety Codes National Fire Protection Association. 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, the Director of Nursing (DON), and the Chief Operating Officer (COO) by phone, were notified of the Immediate Jeopardy (IJ) for F-610 on 10/13/2022 at 5:10 PM. The Administrator, the Director of Nursing (DON) and the Chief Operating Officer (COO) by phone, were notified of the Immediate Jeopardy (IJ) for F-689 on 10/13/2022 at 5:10 PM. The Administrator, the Director of Nursing (DON), and the Chief Operating Officer (COO) by phone, were notified of the Immediate Jeopardy (IJ) for F-835 on 10/13/2022 at 5:10 PM. The facility was cited Immediate Jeopardy at F-610, F-689, and F-835. The facility was cited at F-610 and F-689 at a scope and severity of J which is Substandard Quality of Care. The Immediate Jeopardy existed from 9/13/2022 and is ongoing. (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The findings include: The facility's signed Administrator job description date of 9/4/2022, 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 . The facility's signed Director of Nursing job description dated 9/7/2022, 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 . The facility's QAPI RCA WORKSHEET dated 10/3/2022 documented .Front/entry push pressure emergency opening reprogramed to 50 seconds from 15 seconds 10.3.2022 . During an interview with the Interim Administrator during an entrance conference on 9/16/2022 at 9:30 AM, The Interim Administrator was asked if there was any elopements, Dr. Finds or any incidents that should be looked at by the State Agency since the survey exit date on 8/30/2022. The Interim Administrator stated, .no . (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445387	A. Building B. Wing	10/13/2022

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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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 10/6/2022 at 3:19 PM, with the Maintenance Director and Interim Administrator. The Maintenance Director stated .egress time is still 50 seconds changed that Monday [10/3] . Maintenance Director was asked if front door exit alarm could be heard at both nursing stations. The Maintenance Director stated .depends on where you are in the facility as to whether you can hear the alarms or not . The Interim Administrator stated, .it's that 15 second egress on that door . The Maintenance Director was asked was if the time was reset on the front entrance exit door from 15 seconds to 50 seconds. The Maintenance Director and Interim Administrator looked at each other when the Maintenance Director stated .no it wasn't changed . The Administrator stated .I might have made a typo [mistake typing], I will change that on the summary if that's okay .I have sent paperwork in, but I haven't heard from them yet . During an interview on 10/6/2022 at 4:30 PM, the Interim Administrator was asked why the front entrance door did not open in 15 seconds when the door was tested by the surveyor. The Interim Administrator stated, .I don't know .please .we have worked so hard to get this place back in shape .trying to get the facility new doors that will be locked all the time 24/7 . The Interim Administrator acknowledged the door release was greater than 1 minute and did not open and did not alarm in 15 seconds. During an interview on 9/28/2022 at 10:30 AM, the Interim Administrator confirmed there was no reportable incidents or investigations to be reviewed by the State Agency. During an interview on 9/28/2022 at 12:40 PM, with the Interim Administrator, the Interim DON and the DON, the DON stated, .there was an incident of a missing resident being found in the lobby bathroom of the facility . there were no concerns because the resident was only gone 5 or 10 minutes before she was found . During an interview on 9/28/2022 at 1:15 pm, the Interim Administrator confirmed there were no incidents of a missing resident to report. During an interview on 10/7/2022 at 1:51 PM, the DON stated, .the psychiatric NP said something else was going on with [Resident #1] .uncertain if she would be able to use the call light, she was confused that night when they found her . During an interview on 10/13/2022 at 11:05 AM, the Administrator confirmed incidents should be thoroughly investigated. During the exit conference on 10/13/2022 at beginning at 5:10 PM the COO (who was present via telephone) stated, .it was reported to me that the wander guard door monitor was malfunctioning .the delayed egress was changed from 15 seconds to 50 seconds . Refer to F-610 and F-689.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34153 Based on policy review, medical record review and interview the facility failed to ensure medical records contained a complete and accurately documented representation of resident incidents for 2 of 6 (Resident #2 and Resident #1) residents reviewed for incident and accidents. The facility failed to ensure an accurate medical record for Resident #1 related to Activities of Daily Living (ADLs) and an incomplete nurse note related to an incident, and Resident #2 related to wander guard (a monitoring device to alert staff of a resident attempting to exit the facility unattended) placement and elopement. The findings include: 1.Review of the facility policy DOCUMENTATION POLICY, reviewed October 16, 2021, revealed, . designated staff member will chart on all residents to maintain a complete and accurate medical record .must be accurate, legible, and complete .late entries be completed within 72 hours of the event . Review of the facility's policy titled, REPORTING OF ACCIDENT/INCIDENTS, reviewed November 2, 2021, revealed, . The nurse will complete a narrative notation in the medical record describing the accident/incident . Review of the facility's ELOPEMENT OF RESIDENT POLICY, reviewed 11/21/2021, revealed, .Once the Resident is Located .the charge nurse will document the incident in the resident's medical record including times (time discovered, time of contacts) . 2. Review of the medical record revealed Resident #2 was admitted to the facility on [DATE] with diagnoses of Dementia, Hypertension, Anxiety, Major Depressive Disorder, Insomnia, lack of Coordination and Unsteadiness on Feet. Review of the Elopement Evaluation dated 2/10/2022, revealed score of 3 indicating at risk for elopement . wandering behavior has a pattern and is goal directed .utilize exit alarm . Review of the Minimum Data Set (MDS) dated [DATE], revealed Resident #2 was assessed with a Brief Interview for Mental Status (BIMS) score of 4, indicating she was severely cognitively impaired, required limited assessment to extensive assistance with ADL's, always incontinent of bowel and bladder and used wheelchair for mobility. Review of the care plan dated 7/27/2022, revealed Resident #2 is an elopement risk/wanderer .History of attempts to leave the facility, unattended, impaired safety awareness with interventions .updated 10/2/2022 [after elopement] 1 on 1 at this time .monitor location every shift .maintain wander guard bracelet per MD [Medical Doctor] orders .Check placement every shift . (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a Nurses Notes dated 10/2/2022 documented .Resident being observed being escorted to room . resident was found outside in the security guard's truck .resident walked to the security's guard truck and ask for a ride home .security guard reported he had resident sitting in front seat of truck . Review of a physician verbal order dated 10/2/2022 with start date 10/2/2022 revealed .1:1 observation for safety every shift . Review of the facility Documentation Survey Report Oct-22 revealed there was no documentation of the 1:1 observation for Resident #2 on 1500-2300 (3:00 PM-1:00 AM) shift and 2300-0700 (11:00 PM-7:00 AM) shift on 10/2/2022. During a telephone interview on 10/6/2022 at 1:23 PM, CNA #4 stated .I am agency staff .have only worked at facility a few times .on 10/2/22 I worked 3-11 shift . I did not provide 1 to 1 observation after the incident. I did not provide 15-30 minutes checks for Resident #2 .I checked on during my rounds that night but not 15-30-minute checks .no one told me to do any safety checks .I left when shift ended .she did not have a sitter when I left . During an interview on 10/13/2022 at 5:00 PM, the DON stated, .there is not a place for the Certified Nursing Assistant [CNA] to document 30-minute checks .they can document 1 to 1 observation .[Resident #2] did not have a sitter assigned 1 to 1 observation until the 11-7 shift .I'm not sure why it [wander guard placement] was not signed out by the nurse .Wander guards should be documented every shift for placement . There was no documentation in the medical record to reflect the time of contacts and time discovered for Resident #2's elopement in accordance with the facility's elopement and documentation policies. There was no documentation to reflect that the resident had 1:1 observations immediately after the elopement as ordered. There was not consistent documentation verifying the resident's wander guard was intact. 3. Review of the medical record revealed Resident #1 was admitted to the facility on [DATE] with diagnoses of Schizophrenia, Dementia, Traumatic Brain Injury, and Anxiety. Review of a BIMS assessment completed on 8/22/2022, revealed Resident #1 was assessed with a BIMS of 4 indicating severe cognitive impairment for daily decision making. Review of the quarterly MDS dated [DATE], revealed a staff assessment for Mental Status, modified independence, has some difficulty in new situations. Resident #1 is independent for dressing and requires supervision with eating. Review of the care plan revised 6/22/2022, revealed Resident #1 has ADL (Activities of Daily Living) self-Care performance deficit. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the nurse's progress Draft note dated 9/14/2022 documented, .1220 [AM] during 1st round staff was alert by CNA [Certified Nurse Assistant], Resident was not in her bed or bathroom. Staff directed to look for resident while this nurse searched [NAME] 1 [unit] after 5-10 minutes of direct searching Dr. Find [emergency code called for a missing resident] was call overhead AT 12:20 [AM], Staff continued to search. Approx. [approximately] 5 min [minutes] after Dr. Find was announced, Resident was located by [Licensed Practical Nurse (LPN) #1] in the employee bathroom in the Front Lobby @ [at] 12:30 [AM] .with noted confusion . The nurse note was signed by LPN #2 on 10/8/2022, 24 days after the event occurred. The documented nurses note did not reflect accurate times, the note documented the resident was discovered to not be in her room at 12:20 AM, documented the staff searched for the resident for 5-10 minutes and the called the Dr. Find at 12:20 AM. The nurses note was not actually signed until 24 days after the event and failed to be within the 72 hours in accordance with the facility policy. Review of Resident #1's Documentation Survey Report Sep-22 revealed no documentation of meal percentages and self-performance ability related to eating for the dates 9/3/2022, 9/4/2022, 9/7/2022, 9/8/2022, 9/9/2022, 9/18/2022, 9/24/2022 and 9/25/2022 at 0700 and 1200. There is no documentation on any shift on 9/5/2022. There is no documentation on 9/6/2022, 9/13/2022, 9/14/2022, and 9/20/2022 at 1700. During an interview on 9/28/2022 at 1:45 PM, the Interim Administrator stated, .there is no meal intake documentation for the evening meal on 9/13/2022 [Resident #1], an agency CNA worked that night .are expected to document . During an interview on 10/7/2022 at 1:51 PM, the DON stated, .the staff should be documenting meal intake and the nurses should sign their notes . During a telephone interview on 10/10/2022 at 9:35 AM, LPN #2 stated, .agency staff charting [documentation] is frequently a problem .