STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185096	A. Building B. Wing	07/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Parkwood Health & Rehabilitation	900 Gagel Avenue Louisville, KY 40216

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32635 Based on interview, record review, review of facility policy, and review of a facility investigation, the facility failed to have an effective system in place to ensure resident safety for one (Resident (R) 140) of two sampled residents reviewed for elopements. On 09/04/2022, R140 eloped from the facility unescorted and unsupervised, and required police intervention to locate the resident and return him to the facility. On 06/28/2024, the Administrator and Director of Nursing (DON) were provided a copy of the CMS IJ Template and notified that the failure to ensure residents were provided supervision and protected from further elopement, constituted immediate jeopardy at F 689. The Immediate Jeopardy (IJ) at F 689 also constituted Substandard Quality of Care at 42 CFR 483.25. The IJ was determined to exist on 09/04/2022 when the facility discovered R140 had eloped from the building. The facility completed the following: 1. Resident 140 no longer resides in the facility. (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

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Resident was returned to facility by police at 22:29 on 09/04/2022. A head-to-toe assessment was completed by a licensed nurse on 09/04/2022, the nurse practitioner was notified by a licensed nurse on 09/04/2022, and SBAR [Situation, Background, Assessment Record] was completed on 09/04/2022 by a licensed nurse. (A) An elopement assessment was completed by a licensed nurse on 09/04/2022. (B) Ad Hoc QAPI [Quality Assurance Performance Improvement] meeting was held with the Administrator, Medical Director, Director of Nursing, Admissions Coordinator, Social Services Director, Dietary Manager, Human Resources Director, Housekeeping Director, Activities Director, and Therapy Director on 09/04/2022. (C) One-on-one supervision was initiated, and the care plan was updated by the Interdisciplinary Team (IDT) Director of Nursing, Social Services Director, Therapy Director, and clinical managers on 09/04/2022. (D) The resident Representative was notified in person of the incident by a licensed nurse on 09/05/2022. (E) Every shift behavior monitoring for exit-seeking behavior was continued per MAR and TAR [Medication Administration Record and Treatment Administration Record] on 09/04/2022 until discharge. The resident had a wanderguard placement prior to the incident on 09/04/2022 and was added to the care plan at the time by a licensed nurse. (F) Resident 140 was seen by NP [Nurse Practitioner] and/or physician on 09/06/2022. (G) One-on-one monitoring was placed on orders on 09/08/2022. (H) Resident was monitored by Social Services from 09/06-09/08/2022. (I) Resident 140 was reviewed by IDT for changes in behavior on 09/06/2022. 1. How other residents having the potential to be affected by the same deficient practice will be identified, and what corrective action will be taken: An elopement assessment was completed for 81 residents on 09/04/2022 to 09/06/2022 by licensed nurses. There were 3 residents at risk for elopement at the time the assessment was completed with elopement care plans in place. There were zero new residents identified at risk for elopement at the time the assessments were initiated and completed. Training What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not re-occur? Clinical and agency clinical staff were educated regarding elopement policy and elopement drill beginning 09/04/2022 and completed on 09/12/2022. Education was completed by the Director of Nursing, ADON [Assistant Director of Nursing], MDS [Minimum Data Set] nurse, other nurse managers, and the Dietary Manager. Any staff who fails to comply with the points of the in-servicing would be further educated and /or progressively disciplined as indicated up to termination. As an ongoing practice, an elopement assessment was completed upon admission, quarterly and as needed related to changes in the resident's exit-seeking behaviors. Discussion at clinical meetings of changes in behaviors with review of orders, review of MARs/TARs, care plan review, nurse' notes review, and reports by staff. Care plans will be updated as needed based on these reviews by the clinical leadership and IDT. Individual resident's care plans will be reviewed at least quarterly for needed updates as part of the resident's quarterly care plan conference. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	1. How the corrective actions will be monitored to ensure the deficient practice does not reoccur, (i.e., what Quality Assurance Program will be put into place and by what date the systemic changes for each deficiency will be completed). Resident 140 was reviewed by IDT for changes in behavior on 09/13/2022, 09/21/2022, 09/27/2022, 10/04/2022, 10/25/2022, 11/01/2022, 11/04/2022, 11/08/2022, 11/15/2022, 11/29/2022, 12/05/2022, and 12/16/2022. One on Two monitoring on 09/23/2022 and changed to every 15-minute checks on 11/04/2022 with care plan revisions by licensed nurse, which remained until discharge. Ad Hoc QAPI meeting was held with the Administrator, Medical Director, and Interdisciplinary Team (IDT) on 09/04/2022. (C) Elopement Drills conducted daily for 14 days by the Administrator, Director of Nursing, Housekeeping Supervisor, and /or the Maintenance Director. The QAPI Committee included but not limited to the Administrator, Director of Nursing, Assistant Director of Nursing, Unit Managers, MDS Nurse and Medical Director will review the results. An extended survey was initiated on 07/02/2024, and the State Survey Agency (SSA) validated the facility's IJ Removal Plan on 07/03/2024. Based on the findings of this survey, it was determined the immediate jeopardy was removed and the deficient practice was corrected as alleged on 09/13/2022, prior to initiation of the investigation. Therefore, the IJ was determined to constitute Past Jeopardy. The findings include: A review of the facility policy titled Elopement Guideline, dated 04/05/2023, revealed it was to provide a safe and secure environment for all residents. In the event of resident elopement, the facility would implement its policies and procedures immediately to locate the resident in a timely manner. Elopement was defined as a situation in which a resident leaves the premises or a safe area without staff knowledge and necessary supervision. A review of the facility's undated policy titled, Regarding Missing Residents and Elopement revealed all residents were provided adequate supervision to meet each resident's nursing and personal care needs. All residents would be assessed for behaviors or conditions that put them at risk of elopement. All residents assessed to be at risk of elopement would have this issue addressed in their plan of care. A review of the electronic medical record (EMR) revealed that R140 was admitted to the facility on [DATE] with diagnoses including metabolic encephalopathy and alcohol dependence. A review of the EMR elopement risk assessment dated [DATE] revealed R140 had a low risk score of zero for elopement. A review of an EMR wandering risk assessment dated [DATE] revealed that R140 was at low risk for wandering. A review of the Admission MDS, with an Assessment Reference Date (ARD) of 08/02/2022, revealed the resident had a Brief Interview for Mental Status (BIMS) score of seven out of 15, which indicated the resident was severely cognitively impaired. Per the MDS, the resident used a walker or a wheelchair, and needed physical assistance of one person for ambulation and locomotion. The MDS showed no wandering behaviors as of the date of this assessment. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A review of the EMR progress noted dated 08/07/2022 revealed R140 had been wandering during the night. Per the note, at 5:59 AM, Resident also noted to wander as reported to me by his CNA [Certified Nurse Aide] tonight. Although there was no information in the progress note to indicate exit seeking behavior, a review of the EMR care plan revealed the care plan was updated that same date (08/07/2022) to show that the resident was now actively wandering and may be in other beds or close to exits. In response, interventions were added to place the resident on 15-minute location checks until a physician-ordered wander guard device arrived and placed on the left ankle. A review of the EMR physician's orders dated 08/10/2022 revealed the wander guard device was placed to the left ankle. Placement and function of the wander guard per physician orders was verified per documentation on the MAR. A review of Progress Notes revealed that on 08/18/2022, the resident reported that he was not feeling well. He went out to the emergency room (ER) on 08/19/2022 and returned on 08/20/2022 with no medical diagnosis identified; however, upon return R140 continued to state he did not feel well. On 08/25/2022, R140 was diagnosed as COVID-19 positive and was moved to the COVID Unit on the Southeast Hall. A wandering risk assessment dated [DATE] revealed the resident was now at high risk for wandering, due to a history of wandering and the placement of the wander guard device. This assessment showed the resident was now independent with locomotion in his wheelchair. Further review of the EMR revealed that on 08/31/2022, R140 was moved to a room on the Southwest Hall that was approximately 60 feet from an emergency exit door. A review of the EMR progress note (SBAR), dated 09/04/2022, revealed that at approximately 10:15 PM, Licensed Practical Nurse (LPN) 15, heard the alarm on the Southwest exit door, (which was equipped with a wander guard alarm) sounding. R140 was not in his room and the wheelchair was next to the bed. Staff were alerted and an elopement protocol was enacted. Police were notified and they found the resident, who was returned to the facility at approximately 10:29 PM. R140 was dressed appropriately for the weather and sustained no injuries in response to the elopement. Per the SBAR, the resident stated he was going home, and was placed on one-to-one supervision. Review of the facility investigation revealed that on 09/04/2022, sometime between 10:00 PM to 10:15 PM, R140 exited the facility through the Southwest emergency door, setting off the alarm. Per the investigation, the resident was found at a convenience store which was .6 tenth of a mile from the facility, downhill on a two-lane road. The facility stated the root cause was the resident's desire to go home. Review of the investigation revealed that the facility did not identify how long the alarm had been sounding before staff responded to it. A review of the facility form titled Confidential Witness Statement dated 09/04/2022, revealed LPN15 was in another resident's room to provide care and exited that room sometime between 10:10 PM to 10:15 PM. At that time, she heard the Southwest Door alarming. When she heard the alarm, she asked why the door was alarming and an unnamed resident stated that a tall male went out the door. Per the witness statement, LPN15 started searching the residents' rooms and did not find R140, whose wheelchair was still in his room. She alerted the other staff to search and notified the DON by 10:21 PM. Another nurse called 911 to notify the police of the elopement. At 10:28 PM the administrator was notified and at approximately 10:29 PM, the police returned R140 to the facility. (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 facility records revealed LPN15 was no longer employed at the facility and was unavailable for interview. Review of the witness statements for the other three staff who were assigned to the Southwest Unit that night revealed that all staff were either in resident rooms or on break and had not heard the alarm on the Southwest Door sound. The witness statements indicated that they were unaware that R140 had eloped from the facility until LPN15 identified the issue. Review of witness statements from staff working on the other units revealed that they, also, failed to hear the alarm sound when R140 eloped through the Southwest Hall door. A review of former Social Services progress notes found in the electronic medical record dated 09/06/2022, 09/07/2022, and 09/08/2022, revealed R140 did not remember leaving the facility. Per the resident's closed record, R140 was discharged from the facility on 12/16/2022 and was not available for an interview. Interview with R61 on 07/02/2024 at 9:30 AM revealed he was the resident who saw R140 go out the door and the alarm sounded. He stated he told staff he saw R140 go out the door. R61 could not remember how long the alarm had been sounding prior to staff responding. In an interview with LPN2 on 06/28/2024 at 1:15 PM, he stated he did not remember R140. LPN2 stated the emergency door alarmed if a resident tried to go out the door wearing the wander guard device. In an interview with CNA14 on 06/28/2024 at 2:27 PM, she stated she was one of the staff working on the Southwest Unit on the night that R140 eloped. She stated that she did not recall specifically where she was at the time, and did not hear the alarm sounding, CNA14 stated she was unaware that R140 had eloped. CNA14 stated R140's room was located near the south nurses' station to observe him for wandering the unit and she checked on R140 hourly. Attempts to interview the additional staff who were present on the night of 09/04/2022 were made; however, calls to these staff were not returned. In an interview with the DON on 06/28/2024 at 3:50 PM, she stated she was not the DON when R140 eloped; however, since 2022, the facility had assessments and interventions for elopement in place to ensure residents were safe and elopement does not reoccur. In an interview with the Administrator on 06/28/2024 at 11:05 AM, she stated she was not the Administrator at the time of R140's elopement and the Quality Assurance plan has ensured there have been no other elopements since 2022.