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	12/02/2025

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 - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (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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(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 - Minimal harm or potential for actual harm Residents Affected - Few	Based on interview and record review, the facility failed to ensure each resident received adequate supervision for one of 31 sampled residents (Resident (R) 13). The facility implemented their procedures and a correction plan, and after review of records and interviews it was determined the facility implemented their correction plan as alleged with a completion date of 05/07/2025, prior to survey entry. The findings include: Review of the facility's policy titled, Elopement/Missing Person undated, revealed It is the intent of the facility to provide a safe and home-like environment for all residents and to provide adequate supervision and assistance to prevent accidents. Review of the Logbook Documentation provided by the facility from 03/31/2025 to 09/19/2025 revealed that prior to the week of the elopement on 05/06/2025, the only documented checks were for the Front Entrance, the Northeast Hall, the Northwest Hall, the Southeast Hall, the Southwest Hall, the Dining Room, and the Time Clock Room. The week following the elopement a new section was added called Courtyard Gate. Additionally, it was noted that these checks were only documented five days per week. Review of the monthly calendar revealed the checks were completed weekdays only with no documented evidence to support the checks were completed on weekends. Review of the facility's timeline of the events surrounding R13's elopement revealed that R13 entered the vending machine room on 05/06/2025 at 7:48 PM. At 7:59 PM, R13 left facility grounds through the courtyard gate. A CNA noted that he was missing at 8:16 PM. The nurse was notified at 8:19 PM. R13 was located by staff member outside a store 0.4 miles from the facility at 8:32 PM. Review of weather conditions during this timeframe for 05/06/2025 revealed the evening was mild without precipitation and with temperatures in the 60's to low 70's. Record review revealed the facility admitted R13 on 11/29/2023 with diagnoses that included bipolar disorder, paranoid schizophrenia, depression, and anxiety. Review of the resident's Minimum Data Set (MDS), with an Assessment Reference date of 04/21/2025, revealed R13 was assessed to have a Brief Interview for Mental Status (BIMS) score of three out of 15, which indicated severely impaired cognition. Review of R13's Comprehensive Care Plan (CCP), dated 05/06/2025, revealed the resident was care planned for demonstrating movement behavior that may be interpreted as wandering, pacing, or roaming related to the diagnosis(es) of metabolic encephalopathy, schizophrenia, bipolar, cognitive communication deficit, depression, psychosis, and problems understanding the immediate environment. Further review of R13's CCP, dated 05/06/2025, revealed the resident's symptoms were manifested by: Attempting to leave the facility without a responsible escort (elopement), becoming agitated, oppositional and combative when re-directed. Interventions included preventative strategies such as Assess for potential elopement/unauthorized departure risk, and Post a picture of the resident at/near the front desk and/or nursing station in a discrete place identifying possible elopement risk; staff would be notified of risk potential, and Make rounds/room checks per facility protocol to minimize chance of unauthorized leave.Review of the witness statement on 05/06/2025 from R13 revealed that R13 told the Administrator that he just went to the store to buy some cigarettes and a soda. Review of the witness statement on 05/06/2025 from R30 revealed that this resident told the Administrator that R13 exited the facility via the door in the vending machine room after R30 opened that door for R13. Review of the facility's staff witness statements from 05/06/2025 revealed a Certified Nursing Assistant (CNA)14, who was unable to be interviewed during this investigation, attested that when she came into work on the night of 05/06/2025 she was told R13 was missing. She wrote in her statement that the search had started, and she left and went to the nearby store and saw the resident standing outside the store. She further attested that she asked R13 to get into her car, but he refused so she called the nurse, and they came and got the resident. Review of CNA16 witness statement, dated 05/06/2025, revealed she had taken the resident out to the courtyard to smoke, and they had returned inside the facility. She stated she then heard the alarm, went to check, and R13 was gone. She stated a head count was completed, and the search was initiated. Interview with Licensed Practical Nurse (LPN) 1 on 09/30/2025 at 2:01 PM, revealed she had already left work for the day (of the elopement) but got a phone call from LPN 4 telling her that R13 was missing. She stated she came back to work to help look for him. LPN 1 stated that R13 was known to go to a nearby store, often with his sister when she would sign him out. She reported the resident was found at the same store, down the road from the facility. Review of LPN4's witness statement, dated 05/06/2025, revealed that she attested that a CNA came and informed her that R13 was missing. She stated she immediately began the elopement protocol, completed a head count, and searched the courtyard and then around the premises of the facility. Further review of the statement revealed that when she was