STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075195	A. Building B. Wing	02/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Parkway Pavilion Health and Rehabilitation Center	1157 Enfield Street Enfield, CT 06082

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44675 Based on review of the clinical record, facility documentation, facility policy, and interviews for one (1) of three (3) residents (Resident #1) reviewed for abuse, the facility failed to ensure a resident who had a history of wandering into others residents rooms was free from physical abuse. The findings include: 1. Resident #1 was admitted to the facility with diagnoses that included epilepsy, major depressive disorder, and dementia. The quarterly MDS dated [DATE] identified Resident #1 had a Brief Mental Interview for Mental Status (BIMS) of three (3) indicative of severely impaired cognition, required one staff assistance for activities of daily living (ADL's) and had physical behaviors symptoms directed towards others that occurred one (1) to three (3) days out of seven (7) days. The care plan dated 12/4/24 identified Resident #1 had a behavior problem related to poor safety awareness, dementia, yells out using inappropriate language and verbal aggression/swearing at peers with interventions that included to administer medications as ordered, anticipate Resident #1's needs, assist Resident #1 to develop more appropriate methods of coping and interacting and intervene as necessary to protect the rights of others. A nursing note written by RN #1 dated 12/26/24 at 2:24 PM identified Resident #1 as involved in a resident-to-resident altercation with a fell ow (blind) resident (Resident #2) who wandered into his/her room. The nurse entered the room to obtain Resident #2 and Resident #1 grabbed Resident #2 by the shirt and began swinging. Both residents swung at each other. 2. Resident #2 was admitted to the facility with diagnoses that included dementia, anxiety and major depressive disorder. A reportable event dated 6/24/24 identified that Resident #2 inadvertantly entered Resident #1's room and Resident #1 punched Resident #2 in the face causing a small cut above the eyebrow. The quarterly MDS dated [DATE] identified Resident #2 had a Brief Mental Interview for Mental Status (BIMS) of zero (0) indicative of severely impaired cognition, required one staff assistance for activities of daily living (ADL's), had physical and verbal behaviors symptoms directed towards others that occurred one (1) to three (3) days out of seven (7) days. (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: 075195	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/07/2025
NAME OF PROVIDER OR SUPPLIER Parkway Pavilion Health and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1157 Enfield Street Enfield, CT 06082	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A nursing note dated 11/25/24 at 1:32 PM identified Resident #2 ambulated unsupervised into other resident's rooms. The care plan dated 12/3/24 identified Resident #2 had a behavior problem related to accusatory statements, combative at times and wandering with interventions that included to administer mediations as ordered, anticipate and meet the resident's needs, approach in a calm manner and observe for behavior episodes and attempt to determine the underlying cause. The care plan further identified Resident #2 had impaired cognition related to dementia with interventions that included to cue, reorient and supervise as needed. However, no new interventions were added subsequent to Resident #2 wandering into another resident's room. A nursing note dated 12/12/24 at 10:46 PM identified during the shift, Resident #2 exhibited behavioral concerns, including entering other resident's rooms and sitting on his/her roommate's bed. Resident #2 was very difficult to redirect, as he/she became physically aggressive by hitting and twisting staff member's wrists. A physician's order dated 12/13/24 directed Trazodone 25 mg every eight hours as needed for anxiety for thirty days. A nurse's note written by RN #1 dated 12/26/24 at 2:14 PM identified Resident #2 was involved in a resident-to-resident altercation. Resident #2 sustained a hematoma above the left eye. The physician ordered transport to the hospital for imaging. A nurse's note written by LPN #1 dated 12/26/24 at 4:27 PM identified she arrived to the room after hearing aggressive yelling from another resident. Resident #2 was standing over Resident #1 and before she could re-direct the resident, Resident #2's shirt was grabbed by Resident #1 and the residents quickly got into a physical altercation. Both residents were separated with assistance from staff. The accident and incident form (A & I) dated 12/26/24 identified at 10:45 AM Resident #2 walked into Resident #1's room. Resident #1 yelled get out and the nurse attempted to remove Resident #2 who was blind and accidentally struck the nurse and Resident #1 then hit Resident #2. Resident #1 was sent to the emergency room for evaluation where he/she did not meet inpatient criteria and received a no-harm letter. Resident #2 had a [NAME] to his/her forehead, was sent out to the hospital for a head scan that resulted with no injuries. Interview with NA #1 (Resident #2's regular NA) on 2/7/25 at 2:26 PM identified Resident #2 is blind but wanders all around the unit and into other resident's rooms. She identified h/she touches the walls/railings as he/she ambulates. She identified the interventions she uses when Resident #2 is wandering is to re-direct, stay with Resident #2 and hold his/her hand. Interview with NA #2 (Resident #2's regular NA) on 27/25 at 2:30 PM identified Resident #2 wanders throughout the unit and into other resident's rooms. She could not identify how long Resident #2 had been exhibiting this behavior for. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Parkway Pavilion Health and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1157 Enfield Street Enfield, CT 06082	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with RN #1 on 2/7/25 at 2:28 PM identified Resident #2 was blind and had a history of wandering around the unit, including other resident's rooms. She identified he/she has always wandered inot other residents rooms for as long as she has worked in the facility (approximately 12 months). She identified on 12/26/24 Resident #2 made that motion towards the nurse and Resident #1 thought Resident #2 was hitting the nurse so Resident #1 start hitting Resident #2. She identified Resident #1 has a history of reacting quickly. She identified the interventions utilized for Resident #2 is to re-direct, put Resident #2 in activities, and get Resident #2 up last in the morning so the NA's have better eyes on him/her. Review of the resident's plan of care failed to identify that the resident's history of entering other resdient's rooms had had additional interventions after the 6/24 and 12/26/24 incidents. Interview with the DNS on 2/7/25 at 3:37 PM identified she would expect a new intervention in the care plan for wandering into others rooms if the current interventions had not been successful. Review of the resident-to-resident altercations policy directed to make any changes in the care plan approaches to any or all of the involved individuals. Review of the accident and incidents investigation and reporting policy directed to ensure that interventions are implemented correctly and consistently, evaluate the effectiveness of interventions, modify or replace interventions as necessary and evaluate new interventions when necessary to make them more effective in addressing hazards and risks.

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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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44675 Based on review of the clinical record, facility documentation, facility policy, and interviews for two (2) of three (3) residents (Resident #1 and #2) reviewed for abuse, the facility failed to revise the residents' care plans after a resident-to-resident altercation and update the care plan after wandering behaviors were identified. The findings include: 1. Resident #1 was admitted to the facility with diagnoses that included epilepsy, major depressive disorder, and dementia. The quarterly MDS dated [DATE] identified Resident #1 had a Brief Mental Interview for Mental Status (BIMS) of three (3) indicative of severely impaired cognition, required one staff assistance for activities of daily living (ADL's) and had verbal behaviors symptoms directed towards others that occurred one (1) to three (3) days out of seven (7) days. A psychiatry note dated 6/3/24 identified Resident #1 was seen for agitated behaviors. Resident #1 did not require a 1:1 at that time. The care plan dated 6/5/24 identified Resident #1 had a behavior problem related to poor safety awareness, dementia, yells out using inappropriate language and verbal aggression/swearing at peers with interventions that included to administer medications as ordered, anticipate Resident #1's needs, assist Resident #1 to develop more appropriate methods of coping and interacting and intervene as necessary to protect the rights of others. A Psychiatry note dated 6/6/24 identified Resident #1 was evaluated post resident to resident altercation in which Resident #1 was the aggressor. Resident #1 was yelling and posturing toward a male peer. New orders were to increase Lexapro to 15 mg daily and add Trazodone 25 mg to target anxiety, agitation and impulsivity. The accident and incident (A & I) form dated 6/24/24 at 11:00 AM identified Resident #1 and Resident #2 was observed fist fighting in the doorway of Resident #1's room. The residents were separated. Review of Resident #1's care plan failed to identify Resident #1's (the aggressor) care plan was updated with appropriate interventions following the resident-to-resident altercation on 6/24/24. 2. Resident #2 was admitted to the facility with diagnoses that included dementia, anxiety and major depressive disorder. The quarterly MDS dated [DATE] identified Resident #2 had a Brief Mental Interview for Mental Status (BIMS) of zero (0) indicative of severely impaired cognition, required one staff assistance for activities of daily living (ADL's) and did not have physical and verbal behaviors symptoms directed towards others. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The care plan dated 9/13/24 identified Resident #2 had impaired cognitive function related to dementia. Interventions included to cue, reorient and supervise as needed. The care plan further identified Resident #2 had a behavior problem related to accusatory statements, combative at times and wandering with interventions included to administer medications as ordered, anticipate and meet the residents needs, approach in a calm manner and observe for behavior episodes and attempt to determine the underlying cause. a) A nursing note dated 6/24/24 at 11:13 AM identified Resident #2 wandered into Resident #1's room and Resident #1 began swinging at Resident #2. The residents were separated. Resident #1 acknowledged he/she hit Resident #2 in the head multiple times. Resident #2 was transported to the hospital for an evaluation. The accident and incident (A & I) form dated 6/24/24 at 11:00 AM identified Resident #1 and Resident #2 was observed fist fighting in the doorway of Resident #1's room. The residents were separated, and Resident #2 was sent to the hospital for an evaluation. Review of Resident #2's care plan failed to identify that the care plan was updated with appropriate interventions following the resident-to-resident altercation on 6/24/24 and Resident #2's wandering behavior into another resident's room. Review of the resident-to-resident altercations policy directed to make any changes in the care plan approaches to any or all of the involved individuals. 3. Resident #1 was admitted to the facility with diagnoses that included epilepsy, major depressive disorder, and dementia. The quarterly MDS dated [DATE] identified Resident #1 had a Brief Mental Interview for Mental Status (BIMS) of three (3) indicative of severely impaired cognition, required one staff assistance for activities of daily living (ADL's) and had physical behaviors symptoms directed towards others that occurred one (1) to three (3) days out of seven (7) days. The care plan dated 12/4/24 identified Resident #1 had a behavior problem related to poor safety awareness, dementia, yells out using inappropriate language and verbal aggression/swearing at peers with interventions that included to administer medications as ordered, anticipate Resident #1's needs, assist Resident #1 to develop more appropriate methods of coping and interacting and intervene as necessary to protect the rights of others. 4. Resident #2 was admitted to the facility with diagnoses that included dementia, anxiety and major depressive disorder. The quarterly MDS dated [DATE] identified Resident #2 had a Brief Mental Interview for Mental Status (BIMS) of zero (0) indicative of severely impaired cognition, required one staff assistance for activities of daily living (ADL's), had physical and verbal behaviors symptoms directed towards others that occurred one (1) to three (3) days out of seven (7) days. Nursing note dated 11/25/24 at 1:32 PM identified Resident #2 yelled and ambulated unsupervised into Resident #1's room. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The care plan dated 12/3/24 identified Resident #2 had a behavior problem related to accusatory statements, combative at times and wandering. Interventions included to administer mediations as ordered, anticipate and meet the residents needs, approach in a calm manner and observe for behavior episodes and attempt to determine the underlying cause. The care plan further identified Resident #2 had impaired cognition related to dementia with interventions that included to cue, reorient and supervise as needed. However, no new interventions were added subsequent to Resident #2 wandering into another resident's room. A nursing note dated 12/12/24 at 10:46 PM identified during the shift, Resident #2 exhibited behavioral concerns, including entering other resident's rooms and sitting on his/her roommate's bed. Resident #2 was very difficult to redirect, as he/she became physically aggressive by hitting and twisting staff member's wrists. A physician's order dated 12/13/24 directed Trazodone 25 mg every eight hours as needed for anxiety for thirty days. a) A nurse's note written by RN #1 dated 12/26/24 at 2:14 PM identified Resident #2 was involved in a resident-to-resident altercation. Resident #2 sustained a hematoma above the left eye. The physician ordered transport to the hospital for imaging. A nursing note written by LPN #1 dated 12/26/24 at 4:27 PM identified she arrived to the room after hearing aggressive yelling from another resident. Resident #2 was standing over Resident #1 and before she could re-direct the resident, Resident #2's shirt was grabbed by Resident #1 and the residents quickly got into a physical altercation. Both residents were separated with assistance from staff. The accident and incident form (A & I) dated 12/26/24 identified at 10:45 AM Resident #2 walked into Resident #1's room. Resident #1 yelled get out and the nurse attempted to remove Resident #2 who was blind and accidentally struck the nurse and Resident #1 then hit Resident #2. Resident #1 was sent to the emergency room for evaluation where he/she did not meet inpatient criteria and received a no-harm letter. Resident #2 had a [NAME] to his/her forehead, was sent out to the hospital for a head scan that resulted with no injuries. Review of Resident #2's care plan on 2/7/25 failed to identify new interventions were added to address Resident #2's wandering into other residents' rooms. Interview with NA #1 (Resident #2's regular NA's) on 2/7/25 at 2:26 PM identified Resident #2 is blind but wanders all around the unit and into other resident's rooms. She identified he touches the walls/railings as he/she ambulates. Interview with NA #2 (Resident #2's regular NA's) on 27/25 at 2:30 PM identified Resident #2 wanders throughout the unit and into other resident's rooms. She could not identify how long Resident #2 had been wandering for. (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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with RN #1 on 2/7/25 at 2:28 PM identified Resident #2 was blind and had a history of wandering around the unit, including other resident's rooms. She identified he/she has always wandered into other resident rooms for as long as she has worked in the facility (approximately 12 months). She identified the interventions utilized for Resident #2 is to re-direct, put Resident #2 in activities, and get Resident #2 up last in the morning so the NA's have better eyes on him/her. Interview with the DNS on 2/7/25 at 3:37 PM identified she would expect a new intervention in the care plan for wandering if the interventions listed had not been successful. She identified interventions that were being utilized for Resident #2's wandering was walking with Resident #2 while holding his/her hand, playing music and having Resident #2 sit in the lounge. Review of the accident and incidents investigation and reporting policy directed to ensure that interventions are implemented correctly and consistently, evaluate the effectiveness of interventions, modify or replace interventions as necessary and evaluate new interventions when necessary to make them more effective in addressing hazards and risks. Review of the care plan policy directed to incorporate identified problem areas. It further identified that assessments of residents are ongoing, and care plans are revised as information about the resident and the resident's conditions change. It identified the interdisciplinary team must review and update the care plan when the desired outcome is not met.