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	04/08/2025

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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40172 Based on review of the clinical record, facility documentation, facility policy, and interviews for one (1) of three (3) residents (Resident #1) reviewed for accidents, the facility failed to ensure that a resident who expressed worsening depressive symptoms related to being in the facility did not leave the facility unescorted. The findings include: Resident #1 had diagnoses that included major depressive disorder, cerebral infarction, repeated falls, hemiplegia, and muscle weakness. The quarterly [NAME] Data Set (MDS) assessment dated [DATE] identified Resident #1 had a Brief Interview for Mental Status (BIMS) score of eight (8) indicative of moderately impaired cognition, with the presence of feeling down, depressed, or hopeless for several days, socially isolated sometimes, required touching assistance with transfers, and was independent with locomotion with the use of a wheelchair. Social Worker (SW) #2's note dated 2/12/2015 at 11:20 A.M. identified Resident #1 expressed h/her emotions surrounding being at the facility with new roommates. The note identified that Resident #1 stated I'm tired of being around these people and tired of being here. The care plan dated 2/13/2025 identified Resident #1 had a history of exhibiting signs and symptoms of suicidal ideations as exhibited by verbalizing thoughts of being better off dead and passive suicidal ideations with interventions that directed social service visits one to one as needed, assist with identifying triggers for suicidal ideations and provide alternative healthy coping mechanisms, encourage resident to participate in activities of interest with the social life of facility, encourage resident to share feelings of sadness, hopelessness, or depression, and provide psych services as indicated. SW #2's note dated 2/19/2025 at 11:00 A.M. identified Resident #1 expressed emotions regarding being at the facility stating, I don't want to be in this room or this facility and further indicated h/she wanted to go home with family. (continued on next page)

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
	075195	A. Building B. Wing	04/08/2025

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility accident and incident report dated 3/17/2025 identified, on 3/17/2025 at approximately 7:45 P.M., a visitor reported to NA #1 that a person (Resident #1) was in a wheelchair at the end of the driveway. Registered Nurse (RN) #1 was notified, directed NA #1 to go outside immediately, and sent two additional staff members outside to assist. Resident #1 was noted sitting in h/her wheelchair near the end of the driveway, initially h/she was not agreeable to go back inside the building, but with encouragement h/she agreed, and staff assisted Resident #1 back into the building at 7:43 P.M. Upon arrival back inside, Resident #1 was visibly tearful and h/she expressed suicidal ideation, 911 was called and Resident #1 was transferred to the emergency room for a psychiatric evaluation. SW #2's note dated 3/18/2025 at 1:00 P.M. (late entry note for a visit conducted on 3/16/2025 or 3/17/2025) identified Resident #1 reported increased depressive symptoms due to being at the facility. The facility summary dated 3/21/2025 identified that Resident #1 had diagnoses of major depressive disorder, history of suicidal ideations without attempts, and is followed regularly by psych services for medication and behavioral management. On 3/17/2025 at 7:35 P.M. a visitor notified NA #1 that Resident #1 was seen near the end of the driveway. NA #1 observed Resident #1 sitting upright in h/her wheelchair at the end of the driveway, fully dressed in h/her jeans, sneakers, shirt, and jacket. Initially Resident #1 was resistant to returning to the building, with encouragement h/she went back into the building with staff at 7:43 P.M. Resident #1 was visibly emotional with tears in h/her eyes and stated h/she thought about ending it all and Resident #1 reported that h/she pushed the handicap pad, following a visitor leaving the building. MD #1 was notified, and Resident #1 was transferred to the hospital. Interview with LPN #1 on 4/8/2025 at 10:00 A.M. identified on 3/17/2025 she last saw Resident #1 at 5:00 P. M. when h/she asked for medications and at approximately 7:30 P.M. RN #1 alerted her that Resident #1 was outside. Interview with the Assistant Director of Maintenance on 4/8/2025 at 11:52 A.M. identified that on 3/17/2025 at approximately 7:30 P.M., he was notified by facility staff that Resident #1 was sitting outside at the end of the driveway near the main road. The Assistant Director of Maintenance identified that utilizing a flashlight, he went outside with LPN #1 and other staff to locate Resident #1 who was found seated in h/her wheelchair at the end of the driveway, approximately 250 feet from the front lobby doors, with NA #1. Interview with SW #2 on 4/8/2025 at 12:25 P.M. identified he entered a progress note into the electronic medical record (EMR) on 3/18/2025, due to a delay in entering his progress notes, for a session with Resident #1 on either 3/16/2025 or 3/17/2025. SW #2 identified that during his sessions with Resident #1, h/she verbalized h/she did not want to be in the facility and wanted to live with h/her children. SW #2 identified that, prior to the 3/17/2025 incident when Resident #1 was found outside at the end of the driveway, Resident #1 verbalized increased depressive symptoms related to being at the facility. SW #2 identified he did not notify anyone, including nursing staff or the provider, of the increased depressive symptoms because Resident #1 did not verbalize h/she was going to leave or had a plan to leave the facility. (continued on next page)

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	04/08/2025

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with the DNS on 4/8/2025 at 1:10 P.M. identified on 3/17/2025 RN #1 notified her at approximately 7:30 P.M. that Resident #1 was found outside the building at the end of the driveway. The DNS identified that at 4:00 P.M., the front lobby doors lock, activating the door alarm, and a button must be pushed twice and held in order to enter a code on the keypad to open the doors. The DNS indicated Resident #1 reported h/she exited the building after a visitor was let out and before the doors locked. The DNS identified that after the code was entered to open the doors, there was a 15 second lag period before doors locked and engaged the alarm. The DNS identified that, subsequent to the incident, the doors have been adjusted, and there is no longer a lag period once doors close. The DNS indicated that Resident #1 was not identified as at risk for elopement, and she was not aware Resident #1 verbalized to SW #2 that h/she did not want be in the facility. The DNS identified that if a resident made statements of not wanting to be in the facility, those statements should be reported to the nursing staff. The DNS identified that SW #2 should have notified the charge nurse that Resident #1 verbalized increased depressive symptoms due to being at the facility. Interview with NA #2 on 4/8/2025 at 1:51 P.M. identified she was responsible for providing care for Resident #1 on 3/17/2025 during the 3:00 P.M. to 11:00 P.M. shift. NA #2 identified that Resident #1 refused h/her dinner and at approximately 6:45 P.M., she found Resident #1 sitting in the lobby, drinking a soda, fully dressed, with h/her coat on. At that time, she offered him/her a sandwich, which he/she declined. NA #2 identified that Resident #1 did not usually wear h/her coat inside the facility but that did not occur to her as strange until Resident #1 was found outside. Interview with NA #1 on 4/8/2025 at 4:45 P.M. identified on 3/17/2025 at approximately 7:30 P.M. she observed a visitor standing outside the locked front lobby doors waving h/her hands. NA #1 identified when she unlocked the doors to let the visitor in, the visitor reported a resident was outside at the end of the driveway which NA #1 reported to RN #1. RN #1 directed her to go outside with Resident #1. NA #1 identified she observed Resident #1 sitting in h/her wheelchair at the end of the driveway inches from the road, and Resident #1 was crying. NA #1 identified approximately 3 to 4 minutes later, LPN #1, the Assistant Director of Maintenance, and another NA came outside. NA #1 identified that Resident #1 agreed to go back inside and was assisted back into the building. Review of facility wandering, unsafe resident policy; in part, identified the staff will identify residents who are at risk for harm because of unsafe wandering (including elopement).