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	06/13/2025

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 - 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** 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 a resident who was at high risk for falls and sustained multiple falls with major injuries (fractures) had adequate supervision and adequate fall interventions to maintain safety. The findings include: Resident #1 had diagnoses that included falls, right femur fracture, generalized muscle weakness, need for assistance with personal care, type 2 diabetes mellitus, difficulty walking, generalized muscle weakness, cognitive communication deficit, and unspecified lack of coordination. A Fall Risk Evaluation dated 4/22/2025 by LPN #5 identified Resident #1 was a moderate fall risk. The physician's orders dated 4/23/2025 directed to provide the assistance of one at wheelchair level with ADLs and toileting. The 5-day Minimum Data Set (MDS) assessment dated [DATE] identified Resident #1 was moderately impaired (Brief Interview for Mental Status (BIMS) score of 9), was occasionally incontinent of bowel and bladder, and required moderate assistance with bed mobility, transfers, ambulation, and personal hygiene. The Resident Care Plan (RCP) dated 5/4/2025 identified Resident #1 was at risk for falls related to recent falls at home with a right hip fracture, new to environment, pain, use of diuretic medication, diagnosis of diabetes, and prescribed hypoglycemic medication. Interventions directed to orient to new environment, PT/OT as indicated, appropriate footwear when transferring and/or ambulating, bed in low position (if unable to self-transfer), fall assessment per facility policy, call bell within reach, provide with moderate assistance of one, ambulation and transfers using rolling walker, staff to offer resident assistance to bathroom as needed, and remove walker and wheelchair from bedside while resident is in bed. a. A nurse's note dated 5/4/2025 at 11:53 P.M. by RN #1 identified she was called to Resident #1's room by staff at the change of shift. RN #1 identified upon entering the room Resident #1 was noted to be sitting on the floor in between the beds, with h/her back up against the low bed with h/her legs outstretched. RN #1 indicated when Resident #1 was asked what happened h/she stated h/she was trying to get into the chair (pointing at wheelchair) and fell onto h/her buttocks. (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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F 0689 Level of Harm - Actual harm Residents Affected - Few	Review of Resident #1's right ribs X-ray report dated 5/7/2025 at 1:51 P.M. identified acute appearing right lateral 9 and 10 rib fractures with displacement (broken bones are not in alignment) and mild soft tissue swelling. A nurse's note dated 5/7/2025 at 2:38 P.M. by RN #4 identified Resident #1 fell a few days prior and initially did not complain of pain but currently had pain to the right flank. RN #4 indicated APRN #1 was updated and Resident #1's right unilateral X-ray resulted with acute right rib fractures. Review of a physiatry progress note dated 5/7/2025 at 3:00 P.M. by Physician Assistant (PA) #1 identified Resident #1 was complaining of more intense pain to h/her right posterior rib cage and while sitting up in the wheelchair Resident #1 was uncomfortable. PA #1 identified Resident #1 felt the pain was worse than it was two days ago. The APRN note dated 5/7/2025 at 4:00 P.M. by APRN #1 identified Resident #1 had a fall on 5/4/2025 with no injuries noted at that time, a recent X-ray showed right rib fractures of ribs 9 and 10 with mild soft swelling. APRN #1 indicated Resident #1's right rib fractures are related to h/her most recent fall. Review of the facility's accident and incident report dated 5/7/2025 at 6:28 P.M. identified on 5/4/2025 at 11:05 P.M. Resident #1 sustained a fall, h/she was observed on the floor with back up against the side of h/her bed initially no injury was noted. Resident #1 later developed pain to the flank area and an X-ray was obtained. The X-ray indicated Resident #1 had fractures of ribs 9 and 10 on h/her right side. The facility's summary dated 5/12/2025 identified that on 5/4/2025 Resident #1 had recent assistance with care (prior to the change of shift), h/she was not able to say why h/she was getting up but stated h/she was getting into the wheelchair. Resident #1 was evaluated by therapy services and h/her care plan was updated to change the height of the bed from low position to a position that was most comfortable for safe rise and return to bed. Interview with NA #1 on 6/10/2025 at 12:44 P.M. identified she was assigned to Resident #1 on 5/4/2025 during the 3 PM to 11 PM shift. NA #1 indicated on 5/4/2025 during her shift she conducted rounds every 2 hours. NA #1 indicated that prior to the end of her shift, she and LPN #1 toileted Resident #1 and prior to leaving her shift, she last saw Resident #1 lying in bed. Interview with LPN #1 on 6/10/2025 at 12:55 P.M. identified on 5/4/2025 at approximately 10:45 P.M. she assisted Resident #1 to the bathroom and then back into bed. LPN #1 indicated that when she left the room Resident #1 was in bed resting and at the change of shift NA #2 found Resident #1 on the floor. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Interview with the DNS on 6/10/2025 at 1:17 P.M. identified on 5/4/2025 RN #1 reported Resident #1 was found on the floor in h/her room at approximately 11:05 P.M., RN #1 assessed Resident #1 and noted no injuries, and Resident #1 had no complaints of pain or discomfort. The DNS identified an accident and incident report was completed on 5/4/2025 with a classification of an E because Resident #1 had no injuries. The DNS identified on 5/7/2025 Resident #1 complained of pain in h/her right flank area and a new order was obtained for a unilateral X-ray which resulted positive for fractures of the right 9th and 10th ribs. The DNS identified prior to the fall on 5/4/2025, Resident #1 was identified as at risk for falls, a care plan was in place with interventions, and following the fall on 5/4/2025 the care plan was updated with a new intervention directing to remove wheelchair and walker when Resident #1 was in bed. The DNS identified based on the investigation, Resident #1 got out of bed without calling for assistance and fell. b. A nurse's note dated 5/8/2025 at 12:03 P.M. by RN #4 identified Resident #1 was observed on the floor in the rehab room following a witnessed fall and Resident #1 complained of 3 out of 10 right wrist pain. Resident #1 was scheduled for an orthopedic appointment for the right femur fracture so she applied ice to the right wrist, reported to the orthopedic office, and requested they assess Resident #1's right wrist. Resident # 1 returned from the appointment with a splint applied to the right wrist and confirmed fractures of the distal radius and ulna sustained from the fall at the facility that morning. Review of the facility accident and incident report dated 5/9/2025 at 11:21 A.M. identified on 5/8/2025 at 8:30 A.M. Resident #1 was performing tasks with occupational therapy and tipped to h/her right side, extending h/her right arm which struck the floor and sustained a fracture to h/her right wrist. The facility summary dated 5/12/2025 identified the orthopedic doctor recommended the therapy plan be adjusted to wheelchair level to prevent further falls. A recommendation was made to initiate speech therapy for cognitive loss, a bone density test was scheduled, a medication reconciliation was completed, staff were to encourage participation in activities and to have an increased presence outside of Resident #1 ' s room due to forgetfulness and impulsiveness. Interview with OT #2 on 6/10/2025 at 3:50 P.M. identified on 5/4/2025 Resident #1 was in the gym doing tasks of picking up cones that were of various height that were above h/her waist level, at waist level, and at knee level. OT #1 identified when Resident #1 went to pick up a cone on a step in the gym, h/she fell over with h/her arms extended. c. The revised Resident Care Plan (RCP) dated 5/9/2025 included Resident #1 was at risk for falls related to use of cardiac medications, right wrist fractures, and rib fractures right side. Interventions included provide moderate assistance of one with ambulation and transfers using rolling walker, anticipate increased need for toileting (diuretic), assist with toileting at start of night shift, bed in low position, encourage resident to be within view of staff while awake, and monitor blood sugars as ordered. The RCP failed to identify a toileting schedule despite identifying Resident #1 was at risk for falls and identifying an increased need for toileting due to the use of a diuretic (medication that promotes the removal of excess water and salt from the body through increased urination.) (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	A nurse's note dated 5/13/2025 at 3:05 A.M. by RN #2 identified Resident #1 was found at the bedside on h/her knees and Resident #1 was unsure how the fall occurred but Resident #1 was eager to get into h/her wheelchair. RN #2 identified Resident #1 reported severe pain to the left knee and right ribs. RN #2 identified that redness was noted to the right torso area, MD #1 was notified and Resident #1 was transferred to the emergency department (ED) for further evaluation. Review of the facility accident and incident report dated 5/15/2025 at 5:41 P.M. identified on 5/13/2025 at 2:40 A.M. Resident #1 was found on h/her knees at the bedside. Resident #1 reported severe pain in the left knee and right ribs, with redness present to the right torso area. Resident #1 was last cared for at 1:45 A.M. MD #1 was notified, and a new order was obtained to transfer Resident #1 to the ED for evaluation. Resident #1 had a recent diagnosis of displaced right rib fractures #9 and #10 and remained in the hospital with diagnoses of a non-displaced fracture of right rib #7 and displaced fractures of right ribs #8, #9 and #10. The report indicated Resident #1 would be placed on every 15-minute checks and referred to psych services. The facility summary identified while in the hospital Resident #1 had X-rays and CT scans, the CT scan indicated right sided minimally displaced right rib fractures of #7-10 with small pleural effusion. Review of the hospital Discharge summary dated [DATE] identified Resident #1 was presented as a trauma after an unwitnessed fall; Resident #1 was found on the ground next to h/her wheelchair complaining of right-sided rib pain. Resident #1 was diagnosed with right-sided pleural effusion, hospital acquired delirium, and acute minimally displaced right posterior lateral 7th through 10th rib fractures. A physician's order dated 5/16/2025 directed every 15-minute checks for safety, high fall and fracture risk on every shift. A nurse's note dated 5/16/2025 at 2:41 P.M. by RN #4 identified Resident #1 returned from the hospital, had several falls in the facility, and was very impulsive. RN #4 identified Resident #1 had multiple images obtained which showed additional right rib fractures of #7 and #8 and Resident #1 appeared to be suffering from hospital acquired delirium and impulsivity and would be monitored closely on every 15-minute checks. RN #4 identified Resident #1 was very impulsive although h/she was redirected and transfers self in and out of bed to wheelchair alone. RN #4 identified that since arrival, Resident #1 was getting up from bed multiple times, redirected, and was on every 15-minute checks to try and limit falls. Interview with NA #3 on 6/10/2025 at 1:26 P.M. identified on 5/13/2025 at approximately 1:45 A.M. she checked on Resident #1 who was lying asleep in bed. NA #3 indicated Resident #1 was clean and dry, she repositioned Resident #1, put the bed in a low position, placed the call bell near Resident #1, and left the room. NA #3 identified that Resident #1 was at risk for falls and had previously fallen at the facility. NA #3 indicated that NA #12 was sitting outside of Resident #1's room doing her charting, so she went to complete her rounds. NA #3 identified approximately an hour later she was told that Resident #1 was on the floor in h/her room. NA #3 indicated that Resident #1 complained of pain in h/her right side and was sent to the hospital for evaluation. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Interview with NA #12 on 6/13/2025 at 7:38 A.M. identified that when she worked the 11 P.M. to 7 A.M. shift she would sit outside of Resident #1's room when not caring for other residents because Resident #1 was a high fall risk. NA #12 identified Resident #1 would often not call for assistance and would get up alone. NA #12 indicated she was sitting outside of Resident #1's room in the hallway on 5/13/2025 and at approximately 2:00 A.M. she heard Resident #1 making noise in the room. NA #12 indicated she took Resident #1 to the bathroom and she assisted Resident #1 back into bed then at approximately 2:35 A.M. she heard a loud yell from Resident #1's room and found Resident #1 on the floor kneeling on one knee by h/her bed. Interview with the DNS on 6/13/2025 at 12:34 P.M. identified that on 5/13/2025 at approximately 2:30 A.M. NA #12 heard yelling from Resident #1's room and when she entered the room, she observed Resident #1 was kneeling on h/her left knee next to the bed. The DNS indicated that NA #12 called for help, LPN #3 and RN #2 went to the room, Resident #1 complained of left knee pain, and Resident #1 was transferred to the ED. The DNS identified during the hospitalization Resident #1 had a CT scan that identified Resident #1 had right rib fractures of #7, #8, #9, and #10. The DNS indicated Resident #1 had right rib fractures of #9 and #10 from a previous fall on 5/4/2025. The DNS identified on 5/16/2025 Resident #1 was placed on 15-minute checks to prevent further falls. Although attempted interviews with APRN #1 and RN #2 were not obtained. d.The Resident Care Plan (RCP) dated 5/16/2025 identified Resident #1 was at risk for falls and included interventions to encourage resident to be within view of staff while awake, refer to speech therapy for cognition, provide cues and reminders, every 15-minute checks for safety, and flat call bell. Physician's orders dated 5/17/2025 directed to provide assist of one at wheelchair level for ADLs, with ambulation provide assist of one handheld assist and gait belt, provide assist of one for bed mobility, every 15-minute checks for safety due to high fall risk and fracture risk on every shift. A nurse's note dated 5/17/2025 at 9:23 P.M. by RN #1 identified LPN #4 called her to the unit for a witnessed fall. RN #1 indicated upon arrival Resident #1 was sitting in the wheelchair and had a long scratch to the back of the left arm and an area that looked to be bruising. RN #1 identified Resident #1 was educated on asking for assistance and h/she verbalized understanding. RN #1 indicated Resident #1 was brought to the nurse's station for safety and provided a snack. Review of the facility's accident and incident report dated 5/17/2025 identified Resident #1 had a fall witnessed by NA #5 who observed Resident #1 walking unassisted from the doorway when h/she lost h/her balance and stumbled into the wheelchair in the hallway. RN #1 identified Resident #1 was noted with a 6-inch scratch to the left arm with probable bruising. RN #1 identified MD #1 directed to monitor vital signs every shift for 72 hours and maintain every 15-minute checks. Review of NA #5's written statement dated 5/17/2025 identified she witnessed Resident #1 step into h/her bedroom doorway without clothes or brief on with a urinal in h/her hand. NA #5 indicated as she walked towards Resident #1 h/she spun around, fell on the floor, on h/her bottom, bumping h/her back against the wheelchair that was in the hallway outside the bedroom door. (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 0689 Level of Harm - Actual harm Residents Affected - Few	Review of the RCP dated 5/21/2025 identified Resident #1 was at risk for functional incontinence related to external factors i.e. inability to get to the toilet in time independently and frequently incontinent with interventions that directed to ensure adequate lighting, ensure pathway to toileting area, monitor for skin breakdown, absorbent product as appropriate, pain evaluation and control, and utilize adaptive equipment if appropriate. The RCP failed to identify a toileting schedule despite identifying frequent incontinence and inability for Resident #1 to make it to the toilet in time. Interview with NA #4 on 6/10/2025 at 1:41 P.M. identified on 5/17/2025 she was assigned to care for Resident #1 during the 3 PM to 11 PM shift. NA #4 identified she was aware Resident #1 was a fall risk and Resident #1 was on 15-minute checks. NA #4 indicated at approximately 8:45 P.M. she toileted Resident #1 and assisted Resident #1 back into bed and when she walked past the room again, observed LPN #4 and NA #5 standing next to Resident #1 in the hallway. Resident #1 then self-transferred h/herself back into the wheelchair. NA #4 indicated they brought Resident #1 to the nurse's station so they could monitor h/her for the rest of the shift. Interview with RN #1 on 6/13/2025 at 8:17 A.M. identified on 5/17/2025 she was called to the unit by LPN #4 who reported that she and NA #5 witnessed Resident #1 fall in the hallway landing on h/her buttocks. RN #1 indicated when she arrived on the unit Resident #1 was already sitting in a wheelchair in the hallway outside of h/her room and identified LPN #4 and NA #5 reported that Resident #1 would not wait for them to assist h/her off the floor. RN #1 identified that NA #5 reported when Resident #1 was standing in the doorway with an empty urinal in hand. RN #1 indicated she assessed Resident #1 from head to toe for injuries, noted a scratch on Resident #1's arm, and Resident #1 denied pain or discomfort. RN #1 identified that Resident #1 had been on 15-minute checks since h/her readmission and that Resident #1 had been toileted approximately 15 minutes prior to the fall. RN #1 identified she added a new intervention to empty the urinal as needed and implemented a care plan for functional incontinence. Although attempted, an interview with NA #5 was not obtained. e. Physician's orders dated 5/17/2025 directed to provide assist of one at wheelchair level for ADLs, provide assist of one handheld assist and gait belt with ambulation, provide the assist of one for bed mobility, and every 15-minute checks for safety due to high fall risk/fracture risk on every shift. Review of the initial psychotherapy evaluation dated 5/19/2025 completed by APRN #2 identified she was asked to conduct a cognitive screen for Resident #1. APRN #2 indicated Resident #1 identified feeling confused at times and needing increased care. APRN #2 identified Resident #1 had fair short term and long-term memory and was forgetful. APRN #2 identified she used the short form Brief Cognitive Assessment Tool (BCAT) to evaluate Resident #1 in which h/she scored in the dementia range a seven (7) out of twenty one (21). The 5-day MDS dated [DATE] identified Resident #1 had moderately impaired cognition (Brief Mental Interview for Mental Status (BIMS) score of 9), was occasionally incontinent of bowel and bladder, and required moderate assistance with bed mobility, transfers, ambulation, and personal hygiene. (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 0689 Level of Harm - Actual harm Residents Affected - Few	The Resident Care Plan (RCP) dated 5/23/2025 identified Resident #1 at risk for falls related to recent falls at home with a right hip fracture, new to environment, pain, use of diuretic medication, diagnosis of diabetes, prescribed hypoglycemic medication, use of cardiac medications, fracture of right wrist, and rib fractures right side. Interventions included staff to offer resident assistance to bathroom as needed, anticipate increased need for toileting (diuretic), assist with toileting at start of night shift, bed in low position, encourage resident to be within view of staff while awake, refer to speech therapy for cognition, and flat call bell. The RCP failed to identify a toileting schedule despite identifying Resident #1 was at risk for falls and identifying an increased need for toileting due to the use of a diuretic. A nurse's note dated 5/24/2025 at 10:14 P.M. by LPN #8 identified Resident #1 was seen ambulating without staff, despite encouraging to ask for assistance. LPN #8 indicated that Resident #1's safety was maintained, and Resident #1's 15-minute checks maintained. A nurse's note dated 5/25/2025 10:16 P.M. written by LPN #8 identified Resident #1 was seen several times in the bathroom throughout the shift, despite encouragement, multiple attempts to re-educate to ask for help, and with the call light in reach. LPN #8 indicated Resident #1's 15-minute checks were maintained. Review of the clinical record identified no toileting schedule was initiated despite documentation of Resident #1 being seen several times in the bathroom. A nurse's note dated 5/28/2025 at 1:48 P.M. by RN #4 identified she was notified by the physiatrist (Physician Assistant #1) that Resident #1 presented with a new onset of pain and discomfort of the left femur without known injury. RN #4 identified Resident #1 was rubbing h/her femur and reported pain with standing. RN #4 indicated Resident #1 denied injury or falls. RN #4 identified APRN #1 was notified, and an order was obtained for an X-ray of the left femur to rule out injury or abnormalities. A physician's order dated 5/28/2025 directed to obtain an X-ray of left femur due to a new onset of pain and discomfort. Review of Resident #1's left femur X-ray report dated 5/28/2025 at 2:21 P.M. identified an acute left greater trochanter fracture (palpable bony projection located on the upper femur a bone in the upper thigh) with mild displacement (broken bones are not in alignment). A nurse's note dated 5/28/2025 at 7:16 P.M. by the Director of Nursing (DNS) identified that the RN supervisor reported the bedside X-ray indicated Resident #1 has a fracture of the left greater trochanter. The DNS indicated APRN #1 was in to assess Resident #1 and h/she was lying in bed and appeared in no apparent distress. The DNS identified Resident #1 endorsed pain in the left thigh and described the pain as mild to moderate. The DNS indicated Resident #1's legs were even, no shortening visible, no internal or external rotation of leg, Resident #1 was able to raise both legs independently and bend both knees without difficulty. The DNS indicated that the orthopedic was called, the injury was reported, and a new appointment was scheduled for the following morning. The DNS identified Resident #1 was not able to state if h/she had a fall overnight but Resident #1 has been on 15-minute checks with no events noted in the last few days. (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 0689 Level of Harm - Actual harm Residents Affected - Few	The APRN note dated 5/28/2025 at 9:45 P.M. by APRN #1 identified Resident #1 stated the distal part of the femur was painful on palpation. APRN #1 identified Resident #1 had a history of multiple falls with fractures but denied having fallen. APRN #1 identified Resident #1 had a history of confusion, forgetfulness, and at times, impulsiveness. APRN #1 identified an X-ray of the left hip was ordered to rule out fracture the results show Resident #1 has an acute greater trochanter fracture with mild displacement. APRN #1 identified that an emergent orthopedic appointment was made. Review of the facility accident and incident report dated 5/28/2025 identified the classification as a class B reportable event for an injury of unknown origin. On the morning of 5/28/2025, Resident #1 complained of left leg pain, a bedside X-ray was ordered and resulted with a fracture of left greater trochanter. The report indicated the facility was uncertain if the fracture was related to a previous fall. The facility summary dated 6/3/2025 identified on 5/28/2025, Resident #1 complained of left leg pain and was seen by the physiatry physician assistant. An in-house bedside x-ray was obtained on 5/28/2025 and indicated that Resident #1 had a left greater trochanter fracture with mild displacement. Resident #1 was transferred to the ED for evaluation and a CT scan performed on 5/29/2025 indicated the left greater trochanter fracture appeared unchanged from the CT scan on 5/13/2025. On 5/13/2025 Resident #1 was observed on the floor, complained of left knee pain and right flank pain and was sent to the ED for evaluation. The hospital report indicated Resident #1 had right rib fractures but no further fractures were identified. Resident #1 had been on every 15-minute checks with no indication of a recent fall. A review of Resident #1's previous falls was completed with the most obvious possibility being related to the fall on 5/13/2025 when Resident #1 fell on h/her left knee. A nurse's note dated 5/28/2025 at 10:02 P.M. by LPN #8 identified despite encouragement and education to ring for assistance, Resident #1 transferred independently or attempted to transfer several times throughout this shift and Resident #1 became verbally aggressive with staff when redirected back to bed. LPN #8 identified after the call light was put back in reach Resident #1 was seen dropping the call light off the bed. LPN #8 identified 15-minute checks were maintained with no further issues. Review of the hospital Discharge summary dated [DATE] identified Resident #1 presented to the hospital with left hip pain, after a possible fall. The ED documentation identified an MRI preliminary report showed a left greater trochanter fracture was noted again. Resident #1 was found to have a non-displaced fracture of the greater trochanter of the left femur. Interview with NA #8 on 6/13/2025 at 8:10 A.M. identified she was assigned to care for Resident #1 on 5/27/2025 and 5/28/2025 during the 7 A.M. to 3:00 P.M. shifts. NA #8 identified Resident #1 was a fall risk, would not call for help and often got out of bed without assistance. NA #8 identified Resident #1 always wanted to go to the bathroom. Interview with NA #9 on 6/13/2025 at 10:48 A.M. identified that despite 15-minute checks, Resident #1 would get out of bed without calling for help. NA #9 identified Resident #1 was so fast that she would do the 15-minute checks, take Resident #1 to the bathroom, remind Resident #1 to use the call bell, and still find Resident #1 out of bed. NA #9 identified there was no way to ensure Resident #1 did not get up alone and fall unless Resident #1 was on one to one monitoring. (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	06/13/2025

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 - Actual harm Residents Affected - Few	Interview with the DNS on 6/13/2025 at 12:34 P.M. identified Resident #1 was at risk for falls and had multiple falls with and without injury from 4/23/2025 to 5/17/2025. The DNS identified Resident #1 had an RCP in place that identified h/she was at risk for falls with multiple interventions to prevent falls. The DNS identified that on 5/16/2025 Resident #1 was placed on 15-minute checks due to multiple falls, and on 5/17/2025 despite the 15-minute checks, Resident #1 had a witnessed fall. The DNS identified on 5/28/2025 Resident #1 complained of new onset pain in h/her left leg, the APRN #1 was notified, and an X-ray order was obtained. The DNS indicated she spoke with the hospitalist who identified Resident #1 had a CT scan on 5/29/2025 and the results identified a left greater trochanter fracture which appeared unchanged from the CT scan done on 5/13/2025. The DNS indicated Resident #1's hospital Discharge summary dated [DATE] did not mention a left greater trochanter fracture seen on the CT scan nor did the hospital treat the fracture. The DNS identified on 5/29/2025, when it was confirmed Resident #1 fractured the left greater trochanter, she initiated an investigation for an injury of unknown origin. The DNS indicated based on her investigation, Resident #1 did not have any falls, incidents, or events during the period of 5/18/2025 to 5/28/2025 that could have caused the left greater trochanter fracture, and she attributes Resident #1's fracture of the left greater trochanter to Resident #1's fall on 5/13/2025. The DNS indicated that although there was not a physician's order directing to provide one-to-one monitoring for Resident #1, she would place Resident #1 on one-to-one monitoring when she had the staff. The DNS identified that despite Resident #1 being identified as at risk for falls with impaired cognition, bowel and bladder functional incontinence, frequently observed by staff ambulating to the bathroom without calling for assistance, and staff reports of Resident #1 always wanting to go to the bathroom, Resident #1 was not on a toileting schedule. Although attempted, an interview with APRN #1 was not obtained. Review of the fall and fall risk policy dated March 2018 directed, in part the staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and if falling recurs despite initial interventions, staff will implement additional or different interventions, and if the resident continues to fall staff will re-evaluate the situation and whether it is appropriate to continue or change interventions.