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	11/28/2025

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. (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 - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of clinical records, interviews, and review of facility documentation and policies for one of three residents (Resident #1) reviewed for accidents, the facility failed to provide supervision to ensure a resident was not able to leave the facility without staff knowledge, and failed to ensure a wander assessment was completed timely. The findings included:Resident #1 had diagnoses which included Alzheimer's disease, schizoaffective disorder, bipolar type, and cognitive communication deficit. Review of the quarterly Minimum Data Set assessment (MDS) dated [DATE] identified Resident #1 had a Brief Mental Interview for Mental Status (BIMS) of eleven (11) indicative of moderate cognitive impairment, ambulated independently and had no wandering behaviors. The Resident Care Plan (RCP) dated 10/15/2025 identified an impaired thought processes related to diagnosis of Alzheimer's Disease. Interventions directed to cue, reorient, and supervise as needed. Advanced Practice Registered Nurse (APRN) note dated 10/14/2025 identified Resident #1 was seen due to increased behaviors and mood. Resident #1 presented with symptoms of restlessness, delusions, disorganized behavior, and wandering. Interventions included a dose increase in Cariprazine (for treatment of schizoaffective disorder, bipolar type) from 4.5 milligrams to 5 milligrams, and in Trazodone (for treatment of schizoaffective disorder, bipolar type) from 50 milligrams to 75 milligrams to further address behavioral symptoms, that no acute psychiatric or safety concerns were identified, and to continue to monitor mood, behavior, and medication response. Review of the facility Reportable Event Form dated 10/18/2025 at 12:30 PM identified Resident #1 ambulated independently and was allowed to sit outside independently. At 12:30 staff reported was missing; Resident #1 was last seen at 11:30 AM and was unable to be located at 12:30 PM. A code pink was called and staff attempted to locate Resident #1. A call was received from a group home and informed the facility Resident #1 was there. Resident #1 was picked up and returned to the facility with no injuries identified. Resident #1 stated he/she went to visit a friend at the group home. Further, the report indicated Resident #1 Record review failed to identify a current physician order that directed Resident #1 may sit outside independently. Additional record review failed to identify a wander assessment was completed since 3/8/2024. Nursing note dated 10/18/2025 at 2:00 PM written by RN #1 identified she was alerted by staff that they were unable to locate Resident #1 for lunch at 12:30 PM. A phone call was received by a group home facility at 12:40 PM identifying Resident #1 was at their facility, safe, and requesting transport back to the facility and two (2) staff members were sent to get Resident #1. Upon return, Resident #1 was observed to be dressed appropriately, wearing long pants/shirt, sneakers. The Medical Director was notified and new orders were obtained for the application of a Wander Guard to Resident #1's right ankle and to discontinue the may independently sit outdoors on the front porch order. Review of local weather reports for 10/18/2025 identified the temperature was fifty-seven (57) degrees Fahrenheit, and no wind. Review of Google Maps identified the distance from the facility to the group home was 1.2 miles. Interview and documentation review with RN #1 on 10/31/2025 at 11:01 AM identified Resident #1 was last seen by NA #1 and a visitor when he/she went outside at 11:30 AM. Staff were unable to locate Resident #1 for lunch at 12:20 PM, and a code pink (facility missing resident code) was called and staff searched the building. A call was received at 12:40 PM (1 hour and 10 minutes after Resident #1 was last seen by staff) from a group home, stating Resident #1 was at the group home. RN #1 sent staff to pick Resident #1 up and return him/her to the facility. An assessment was completed, and no injuries were identified. RN #1 stated Resident #1 had no prior history of elopement, and a Wander Guard bracelet was applied upon return to the facility to prevent Resident #1 from leaving the facility without staff knowledge. Interview and record review with the Director of Nursing Services (DNS) on 10/31/2025 at 1:55 PM identified although Resident #1 did not present with behaviors that would indicate he/she was at risk for elopement prior to the 10/18/2025 incident. The DNS stated wander assessment were completed on residents upon admission to the facility and for a change in condition; they were not completed quarterly or annually and the last assessment completed for Resident #1 was 3/8/2024 (19 months and 10 days prior). Although interview identified staff should have known Resident #1's whereabouts, Resident #1 was last seen about 11:30 PM, and at 12:20 staff were unable to locate Resident #1. Resident #1 was located when the group home notified the facility at 12:40 (approximately 1 hour and 10 minutes after Resident #1 was last seen) and staff should have known Resident #1's whereabouts. Interview failed to identify why a wander assessment was not completed when wandering behaviors were identified by the APRN on 10/14/2025. The DNS further indicated since the