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	04/01/2026

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 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the resident's doctor reviews the resident's care, writes, signs and dates progress notes and orders, at each required visit. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, facility documentation review, facility policy review, and interviews for three of three residents (Residents #1, #5 and #6) reviewed for accidents, the facility failed to ensure the physician orders were signed and dated timely to indicate the physician/APRN reviewed and renewed the physician orders. The findings include: Resident #1's diagnoses included dementia, dysphagia and anxiety. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified that Resident #1 had a Brief Interview for Mental Status (BIMS) score of six out of fifteen, indicative of severe cognitive impairment and was dependent for ADLs. The Resident Care Plan (RCP) dated 1/15/2026 identified Resident #1 had an ADL self-care deficit. Interventions directed to assist as needed. Record review identified Resident #1 was on an every 60-day schedule for review and renewal of physician orders. Record review identified although interim physician orders were signed, the monthly physician orders were not signed by MD #1 beginning September 2025 through April 1, 2026. Interview with the DNS and RN #2 on 4/1/2026 at 11 AM identified the facility was unable to provide last the signed 60-day physician orders for Resident #1. b. Resident #5's diagnoses included dementia, anxiety, and dysphagia. The annual Minimum Data Set (MDS) assessment dated [DATE] identified that Resident #5 had a Brief Interview for Mental Status (BIMS) score of three out of fifteen, indicative of severe cognitive impairment and was dependent for ADLs. The Resident Care Plan (RCP) dated 1/15/2026 identified Resident #5 had an ADL self-care deficit. Interventions directed to assist with personal care. Record review identified Resident #5 was on an every 60-day schedule for review and renewal of physician orders. Record review identified although interim physician orders were signed, the monthly physician orders were not signed by MD #1 beginning September 2025 through April 1, 2026. c. Resident #6's diagnoses included dementia and dysphagia. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #6 had a Brief Interview for Mental Status (BIMS) score of one out of fifteen, indicative of severe cognitive impairment and was dependent for ADL care. The Resident Care Plan (RCP) dated 2/26/2026 identified Resident #6 had an ADL self-care deficit. Interventions directed to assist with personal care. Record review identified Resident #6 was on an every 60-day schedule for review and renewal of physician orders. Record review identified although interim physician orders were signed, the monthly physician orders were not signed by MD #1 beginning September 2025 through April 1, 2026. Interview and record review with the DNS on 4/1/2026 at 12:57 PM identified MD #1/Medical Director had been signing physician orders electronically for about the last six (6) months. Additional review identified MD #1 had only signed the interim (new) physician orders and also signed orders for any residents that were discharged from the facility. Routine standing orders, every 30- or 60-days, were not signed by the physician or APRN. The DNS stated resident physician orders should be signed by the MD at least every 60 days, and she did not know why the orders were not signed. Interview and record review with Corporate RN/RN #2 on 4/1/2026 at 3:15 PM identified MD #1 had been signing the physician orders electronically for about six (6) months, however, the only orders that were signed were orders for residents that were discharged from the facility. RN #2 stated all standing/monthly orders were required to be signed at (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 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	least every 60-days. RN #2 was unable to provide signed MD orders. RN #2 stated the software system was not set to trigger orders to be signed by the MD, it only triggered residents that were discharged from the facility for the MD to sign. Review of facility Physician Services Policy directed in part, electronic signatures and orders were permitted in accordance with recognized standards and laws. Electronic signatures may be placed in the Electronic Medical Record (EMR). The computer program controls access to information based on the individual's personal identifier code and professional qualifications. The Policy further directed the time and date of orders are recorded by the computer.