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	09/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Parkway Pavilion Health and Rehabilitation Center	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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. 50167 Based on observations of the Environment and staff interviews for 1 of 4 units for the East South wing, the facility failed to provide a homelike, clean and safe environment for Resident #89. The findings include: Observation of Resident #89's lower wall behind the bed during the initial facility tour on 9/04/24 at 10:47AM identified the window noted with a large area of chipped wall paint, detached floorboard panel with a brown-like substance on the lower half of the wall and the floor behind Resident #89's bed. Interview with Resident #89 on 9/04/24 at 10:47AM identified the lower wall behind the bed has been in this condition for some time and s/he reported it to staff members but could not recall exact names. Interview with the Director of Maintenance on 9/11/24 at 9:30AM identified s/he was not aware of the condition of the wall needing repair. The Director of Maintenance also indicated s/he does not participate in the monthly Environmental Rounds of the facility. The Director of Maintenance identified at the end of the interview that staff may have mentioned the wall in Resident # 89's room needing repair and he/she forgot about it. After surveyor inquiry, on Monday 9/9/24 the wall was fixed. The Environmental Round logs were reviewed for the months of April 2024, May 2024, June 2024, July 2024, and August 2024 failed to identify the wall in Resident # 89's room in need of repair. Review of the Environmental Rounds Policy given during the survey notes environmental rounds should be conducted monthly and will include a Maintenance Representative.

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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	075195	A. Building B. Wing	09/11/2024

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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** 48880 Based on clinical record reviews, observation, and staff interviews, for 1 of 6 residents reviewed for abuse (Resident #110), the facility failed to protect a resident's right to be free from verbal abuse by a resident with a history of resident-to-resident altercations (Resident #6). The findings include: 1. Resident #6's diagnoses include unspecified psychosis, unspecified dementia, and depression. A quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #6 as severely cognitively impaired and required supervision or touching assistance for transferring from bed to chair and for walking ten feet. A Resident Care Plan dated 5/7/2024 identified Resident #6 had a history of witnessed physical altercations with other residents including a prior roommate. The care plan indicated the altercations occurred on 2/22/2024 and on 5/7/2024. Interventions included separating the involved residents, social service follow-up, and psychiatry follow-up. 2. Resident #110 was admitted on [DATE] with a diagnosis of generalized muscle weakness and generalized anxiety disorder. A care plan dated 7/28/2024 identified Resident #110 had a self-care performance deficit. Interventions included: bed mobility and transferring assistance of one staff member. Additionally, the care plan indicated that Resident #110 had a mood problem related to anxiety and insomnia; interventions included encouraging the resident to express feelings and providing a calm, quiet environment The quarterly MDS assessment dated [DATE] identified Resident #110 had moderate cognitive impairment and required partial/moderate assistance for bed mobility and for transferring from bed to a chair. An observation on 9/4/2024 at 11:02 identified a surveyor overheard Resident #6 speaking loudly towards Resident #110 saying, are you going to stay in bed all day stupid, your stupid. Both Resident # 6 and Resident # 110 were observed to be lying in bed and the curtain separating the beds was open. Resident #110 indicated that Resident #6 spoke to her/ him in that manner all the time and indicated s/he felt hurt by it. A nursing note dated 9/4/2024 indicated Resident #6 and Resident #110 were separated, and Resident #1 was redirected and removed from the room. On 9/9/2024 at 1:30 PM an interview with Resident #6 indicated s/he did not recall having a verbal altercation with her/his roommate. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/9/2024 at 1:45 PM an interview with Resident #110 indicated s/he did not recall any verbal or physical aggression towards her/him. On 9/9/2024 at 2:00 PM an interview with Licensed Practical Nurse (LPN #8) identified although s/he has not witnessed Resident #6 being verbally or physically aggressive towards others s/he knew Resident #6 had altercations with other residents in the past. Additionally, LPN# 8 indicated when Resident #6 is exhibiting behaviors staff will redirect Resident # 6 with snacks, going outside or playing cards. On 9/10/24 at 12:21 PM, an interview with the Advanced Practice Registered Nurse (APRN) #3 indicated Resident #6's behaviors are likely due to the resident's impulsiveness and frustration intolerance. Additionally, APRN #3 indicated Resident #6 was not an immediate danger to self and others. The facility policy for abuse given at time of survey indicated a licensed nurse will closely monitor and document the behavior of the residents involved in an altercation to prevent the recurrence of the incident.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46046 Based on clinical record reviews, facility documents, review of facility policy and interviews for 2 of 6 residents (Residents #89 and # 106) reviewed for abuse, the facility failed to protect residents from abuse by not immediately removing an alleged staff member from the facility per facility policy. The findings included. 1. Resident #89's diagnoses included poly neuropathy, chronic pain, Type 2 diabetes mellitus, and anxiety disorder. The quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #89 was cognitively intact. Resident #89's care plan dated 7/10/2024 indicated Resident #89 has chronic pain and requires pain medication. Interventions directed to observe adverse reactions with every interaction with the resident. The care plan dated 7/30/2024 indicated Resident #89 was noted to have accusatory behaviors towards staff, throwing items secondary to anger and prefers to stay in bed most of the time. Interventions directed to have 2 caregivers at all times and to provide psychiatric services as needed. A Reportable Event (RE) dated 9/4/2024 at 1:00PM indicated Resident #89 had indicated Nurse Aide (NA)#5 had allegedly not provided incontinent care and placed 2 briefs on Resident # 89 instead of one brief. Additionally, the RE noted NA # 5 took Resident #89's personal mechanical lift pad and threw it onto the resident's feet while in bed. The report further indicated NA#5 was suspended pending further investigation. On 9/10/24 at 12:34 PM the Director of Nursing Services (DNS) provided a copy of timecard punches which documented NA #5 punched in at 12:53 AM for in class in-service and once done with the class punched out and at 3:15 PM and was sent home. The DNS further indicated NA#5 was not taking care of residents during this time. An interview with Registered Nurse (RN #1) on 9/11/2024 at 8:30 AM indicated NA #5 was attending in-service training at the time but staff was not made aware of the allegation until 1:00 PM therefore NA # 5 was not sent home immediately. RN #1 further indicated in the future the alleged staff member will be reached immediately to determine where abouts and staff member will be immediately removed pending completion of the investigation. After, the incident licensed staff received in-servicing on removal of staff. The facility policy labeled Abuse prohibition and quality Assurance/Reporting Reasonable Suspicion of Crime-Elder Justice Act dated 7/16/2024 indicated in part a staff member identified in the allegation would be immediately suspended pending the outcome of the investigation to ensure prohibition and prevention of retaliation. 2. Resident # 106's diagnoses included diagnoses include Multiple Sclerosis, dysfunctional bladder, depression anxiety, asthma and morbid obesity. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The quarterly MDS assessment dated [DATE] identified a BIMS of 15 indicating the resident as cognitively intact and no memory problems The care plan dated for assistance with ADL dated 7/17/24. Interventions included to provide the assistance of one person and get the resident out of bed into a wheelchair. A Reportable Event dated 9/4/24 identified while investigating Resident # 89's allegation of NA #5 not providing incontinent care to the resident. Upon interview with Resident # 106 on the same day identified Resident # 106 indicated on 9/4/24 a nurse aide applied two briefs on her/him and failed to provide incontinent care. Resident # 106 agreed to body audit and no irregularities were noted. The NA was suspended pending investigations. Interview with Resident # 106 at 12:05 PM identified the nurse aide likes to do this to me and other people. The nurse will place two briefs on us. The nurse aide will put one brief on and then later around 7-8 PM she will add another brief on or diaper without cleaning me. The nurse aide will also will ask me to left up so s/he can place the second brief on me which was very painful. The nurse aides does not clean you before putting on the second diaper, one time I had a bowel movement and the nurse aide just put the new diaper on top of the old one without washing me. On 9/10/24 at 12:34 PM the Director of Nursing Services (DNS) provided a copy of timecard punches which documented NA # 5 punched in at 12:53 PM for in class in-service and once done with the class punched out and at 3:15 PM and went home. Interview with the DNS on 9/11/24 at 1:30 PM indicated NA# 5 came in for an inservice before staff could notify her/him of the allegation. The DNS reviewed the abuse policy in the presence of the survey and indicated per facility abuse policy the nurse aide should have been removed from the building immediately pending investigation. After, inquiry the DNS begin on 9/11/24 in-servicing the licensed staff to immediately remove staff who have been allegedly accused of abuse from the building.

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	075195	A. Building B. Wing	09/11/2024

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37721 Based on clinical record reviews and staff interviews for 1 of 4 sampled residents, (Resident #74) reviewed for Preadmission Screening and Resident Review (PASRR), and 1 sampled resident, (Resident #121) reviewed for hospitalization , the facility failed to ensure the accuracy of the Minimum Data Set (MDS) assessment coding for 1 of 3 (Resident #79) residents reviewed for Respiratory Care, the facility failed to ensure the resident's utilization of oxygen was coded correctly on the MDS assesssment. The findings included: 1. Resident #74's diagnoses included schizophrenia and unspecified intellectual disabilities. The Notice of PASRR Level II Outcome dated 11/11/21 identified Resident #74 with diagnoses of severe mental illness/intellectual disabilities and noted the resident was approved without the need of specialized services. The Annual Minimum Data Set assessment dated [DATE] identified Resident #74 as severely cognitively impaired and required one person assist with activities of daily living and was not considered by the state to have a serious mental illness/intellectual disability (MI/ID). The MDS failed to reflect that Resident #74 had a diagnosis of MI/ID. An interview with Social Worker, SW #1 on 9/10/24 at 10:23 AM identified s/he was responsible for coding the MDS for any resident with MI/ID. Although SW #1 was aware that Resident #74 met criteria, s/he did not code the MDS accurately as an oversight. An interview with the Director of Nursing Services (DNS) on 9/10/24 at 12:35 PM identified s/he would expect the MDS to be accurately coded for a resident with a positive PASSR outcome. The Resident Assessment Instrument, RAI October 2023 (used to assess the needs and strengths of a resident) directs a resident with approved level II PASRR determination be coded (1) or 'Yes' to indicate the resident is considered by the state to have MI/ID. 2. Resident #121's diagnoses included atrial fibrillation and hypertension. A Nursing Admission assessment dated [DATE] identified Resident #121 as alert and confused and indicated the resident was admitted for maintaining functional level until discharge home. The Resident Care Plan dated 8/3/24 identified a deficit in activities of daily living (ADL) and a discharge plan to return home with family after respite. Interventions directed to provide assist as needed for ADL care and discuss discharge planning. A nurse's note dated 8/5/24 at 2:44 PM identified Resident #121 was discharged home with family with no complaints. The discharge Minimum Data Set (MDS) assessment dated [DATE] identified Resident #121 was discharged to an acute hospital with return not anticipated. (continued on next page)

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	075195	A. Building B. Wing	09/11/2024

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview with Registered Nurse, RN #6 on 9/10/24 at 9:35 AM identified s/he was responsible for coding the MDS for residents discharged from the facility. RN #6 identified s/he did not accurately code Resident #121's discharge status secondarily to being an oversight. An interview with the DNS on 9/10/24 at 12:35 PM identified s/he would expect the MDS to be accurately coded for a resident being discharged from the facility. The Resident Assessment Instrument, RAI October 2023 (used to assess the needs and strengths of a resident) directs the coding the discharge event to track where the resident is going and ensure accuracy of the assessment. 3. Resident #79 's diagnoses included heart failure, Obstructive and Reflux Uropathy and anxiety. The care plan dated 4/29/24 identified Resident #79 is non-compliant with keeping oxygen on. Interventions include for staff to replace oxygen on resident as needed resident encouraged to keep oxygen on. A physician's order dated 7/15/24 directed to change oxygen tubing & set-up weekly every night shift every Sunday label tubing with date when changed as needed label tubing with date when changed. The quarterly Minimum Data Set assessment (MDS) dated [DATE] indicated resident was cognitively impaired and required two person assist with bed mobility and transfers. The MDS also indicated the resident was not on oxygen during the assessment period. Interview with Licensed Practical Nurse (LPN #1) on 9/09/24 at 10:01 AM indicated stating 'No' in section O of the MDS regarding oxygen was a coding error. After to inquiry, Resident # 79's section 'O' in the MDS was changed to indicated yes resident is on oxygen. 49100

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	075195	A. Building B. Wing	09/11/2024

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46046 Based on review of the clinical records, review of facility policy and interviews for 1 of 3 residents (Resident #72) reviewed for Respiratory Care, the facility failed to ensure the care plan reflected the needs of the resident and for 1 of 2 residents (Resident # 120) reviewed for hospice, the facility failed to develop a comprehensive care plan to address the resident's needs. The findings included: 1. Resident #72's diagnosis includes a muscle disorder with generalized muscle weakness, acute respiratory failure with hypoxia (low oxygen) and obstructive sleep apnea. The Registered Nurse (RN) admission note dated 7/31/2024 at 5:03 PM indicated in part Resident #72 had a tracheostomy tube (Trach) capped as tolerated and utilized a non-mechanical ventilator (AVAPS) The admission Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #72 as cognitively intact, tracheostomy (Trach) care and and noted use of a non-invasive mechanical ventilator. The care plan dated 8/12/2024 Resident #72 noted stage 1 wound (non-blanchable redness) on the bridge of the nose. Intervention included: to assist/encourage to apply silicone cover to the nasal bridge under the AVAPS (Average Volume Assured Respiratory Support a Non-Mechanical Ventilator) mask at bedtime. However, further review of clinical record identified no care plan in place regarding Resident #72's tracheostomy or AVAPS use and care. The physician's orders dated 8/30/2024 directed to provide trach care twice daily and as needed for preventative measure. An interview and record review with the Assistant Director of Nursing Services (ADNS) on 9/9/2024 at 10:50 AM indicated no care plan was initiated for care of Resident #72's tracheostomy and indicated a care plan should have been put in place by the MDS nurse to meet the resident's needs. An interview and record review with RN #6, the MDS Nurse, on 9/9/2024 at 11:16 AM indicated tracheostomy and the AVAPS non-mechanical ventilator must have been overlooked while completing the care plan. After surveyor inquire, the care was revise to reflect the resident's needs for tracheostomy care. The care plan dated 9/9/2024 indicated in part, Resident #72 had altered Respiratory status due to difficulty breathing at night. Interventions to included: applying the AVAPS at bedtime with the silicone barrier applied on the bridge of nose and daily cleaning of AVAPS. The care plan further indicated Resident #72 had a tracheostomy for breathing due to respiratory failure Interventions included : to complete tracheostomy care as ordered, utilized enhanced barrier precautions, maintain an Ambu bag (to provide artificial respirations by hand) at bedside, replacement tracheostomy tubes of equal and one size smaller at bedside and the respiratory therapist to evaluate, provide interventions as needed or requested, and suction the trach as needed or requested. (continued on next page)

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	075195	A. Building B. Wing	09/11/2024

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

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility policy labeled Care Plans, Comprehensive Person Centered dated 7/16/2024 indicated in part the comprehensive person centered care plan will describe services that are to be furnished to attain or maintain the residents highest practical wellbeing. 2. Resident #120 's diagnoses included Emphysema, Chronic Obstructive Pulmonary Disease, and Dementia. The quarterly Minimum Data Set assessment dated [DATE] identified Resident #120 was severely cognitively impaired and required extensive assistance with toileting, was independent with bed mobility and transfers. The Resident Care Plan dated 6/26/24 identified Resident #120 had a potential for pain related to general discomfort. Interventions included to observe daily for discomfort and effectiveness of interventions. There was no care plan for hospice services identified. A physician's order dated 7/1/24 directed to hospice services to evaluate and admit if appropriate As Soon As Possible (ASAP). A nurse's note dated 7/2/24 at 1:51 AM identified the resident was on hospice and a family member was at bedside. No issues overnight. Interview and record review with DNS on 9/11/24 at 11:50 AM identified s/he could not find any hospice plan of care or any care conferences at this time. Review of the Hospice Policy given during the survey directed, in part, that the facility will obtain information from the hospice service including the most recent hospice plan of care.

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	075195	A. Building B. Wing	09/11/2024

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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** 46046 Based on clinical record review, facility policy and staff interviews for 1 resident reviewed for edema (Resident #61), the facility failed to update/ revise the resident's care plan. The findings include: Resident #61 was admitted to the facility on [DATE]. Resident #61's diagnoses included Congestive Heart failure (CHF), cellulitis of the right lower limb and lymphedema. The admission Minimum Data Set (MDS) assessment dated [DATE] identified Resident #61 as cognitively intact. Resident #61 was transferred to the hospital on 7/2/2024 and readmitted to the facility on [DATE]. A physician's order dated 7/14/2024 directed to obtain a daily weight for CHF monitoring and to notify the physician if there was a gain of 2 pounds in 24 hours or 5 pounds gained in a week. The RCP dated 8/30/2024 indicated Resident #61 had a nutritional problem or the potential for a nutritional problem related to CHF and use of a diuretic (water pill). Interventions included: to restrict fluid intake and obtain laboratory work as ordered and to observe for symptoms of edema(swelling), and shortness of breath. The RCP further indicated Resident #61 had a potential for a fluid deficit. Intervention included administering medications as ordered and to monitor and document intake and output per facility policy. An interview on 9/11/2024 at 10:30 AM with Registered Nurse (RN #6) indicated Resident #61's care plan had no reference for the need to obtain a daily weight and to report to the physician a weight gain of 2 pounds in 24 hours or 5 pounds in a week as part of CHF monitoring. RN#6 further indicated s/he would update the care plan. The facility policy labeled Care plans, Comprehensive Person Centered dated 7/16/2024 indicated in part; the interdisciplinary team must review and update the care plan when there is a significant change in a resident's condition, when the desired outcome is not met, when the resident is readmitted to the facility from a hospital stay and at least quarterly in conjunction with the required quarterly MDS assessment.

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	075195	A. Building B. Wing	09/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37721 Based on clinical record reviews, review of facility policy and interviews for 1 resident (Resident #50) reviewed for pain, the facility failed to follow up on the residents Ear, Nose and Throat (ENT) appointment per physician's order timely and for 1 resident (Resident # 61) reviewed for edema, the facility failed to conduct weights per physician's orders and for 1 resident (Resident # 120) reviewed for End of Life/ Hospice, the facility failed to follow the plan of care. The findings included: 1. Resident #50's diagnoses included chronic kidney disease, Chronic Obstructive Pulmonary Disease (COPD) and unspecified hearing loss. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #50 as cognitively intact and noted the resident required supervised set up assist with bed mobility, two persons assist with transfers. The Resident Care Plan dated 7/9/24 identified Resident #50 had a potential for pain related to general discomfort and a hearing impairment. Interventions directed to administer pain medication as ordered, observe for signs of pain and to encourage calm, quiet locations for conversation. A Nurse Practitioner, NP note dated 8/15/24 identified Resident #50 had complaints of dizziness was managed with Meclizine at home (antihistamine used for the treatment of dizziness). Pain was managed. Cerumen (wax buildup) was also noted in both ears. The plan included Debrox drops to both ears every evening for (5) days for the treatment of cerumen impaction and to monitor for improvement. The physician's orders dated 8/15/24 directed Debrox drops to both ears every evening for (5) days and Meclizine 12.5 Milligrams (MG) every eight hours for dizziness. The Medication Administration Record (MAR) dated 8/15/24 through 8/21/24 identified Debrox was completed on 8/21/24. A review of the nursing and NP progress notes dated 8/21/24 through 9/4/24 did not identify any documentation related to the ear wax impaction following treatment An interview with Resident #50 on 9/4/24 at 10:22 AM identified s/he had been experiencing pain in the left ear, likely from wax. The left ear pain was reported to the nurse many times and Resident # 50 was told s/he had to wait for a specialist to come in to evaluate. An interview with Licensed Practical Nurse, LPN #7 on 9/9/24 at 12:28 PM identified s/he attempted to contact the Ear, Nose and Throat (ENT)'s office on one occasion sometime within the preceding two weeks, but the office was closed. LPN #7 further identified s/he did not attempt again, pass the information to another shift for follow up or notify the nursing supervisor the appointment required scheduling. (continued on next page)

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	075195	A. Building B. Wing	09/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview with NP #1 9/9/24 at 12:33 PM identified s/he evaluated Resident #50 who had been complaining of dizziness and noted ear wax bilaterally. NP #1 identified s/he ordered Debrox for the wax removal. NP #1 further identified Resident #50 was subsequently referred to an ENT within the preceding two weeks and would expect that attempts to schedule an appointment be completed once referred. An interview with the DNS on 9/9/24 at 12: 36 PM identified s/he would expect the appointment for a specialty service to be made as soon as possible after the referral. An appointment for ENT was scheduled after a surveyor inquiry. Although requested, a policy for facilitating community specialty service referrals was not provided. 2. Resident #61 was admitted to the facility on [DATE]. Resident #61's diagnoses included Congestive Heart failure (CHF), cellulitis of the right lower limb and lymphedema. The admission Minimum Data Set (MDS) assessment dated [DATE] identified Resident #61 as cognitively intact. Resident #61 was transferred to the hospital on 7/2/2024 and readmitted to the facility on [DATE]. A physician's order dated 7/14/2024 directed to obtain a daily weight for CHF monitoring and to notify the physician if there was a gain of 2 pounds in 24 hours or 5 pounds gained in a week. The RCP dated 8/30/2024 indicated Resident #61 had a nutritional problem or the potential for a nutritional problem related to CHF and use of a diuretic (water pill). Interventions included: to restrict fluid intake and obtain laboratory work as ordered and to observe for symptoms of edema(swelling), and shortness of breath. The RCP further indicated Resident #61 had a potential for a fluid deficit. Intervention included administering medications as ordered and to monitor and document intake and output per facility policy. An interview and record review with the nursing supervisor (RN #2) on 9/9/2024 at 1:35 PM indicated Resident #61 has an order for daily weights dated 7/15/2024. The residents' weights are scheduled to be obtained at 6:00 AM. During review of the weight monitoring with RN #2 from 7/25/2024 through 9/9/2024, the following were identified: There was no documentation of weights obtained or in a nurse's notes to indicate reason why the weights were not obtained on 7/27, 7/28, 7/30, 8/1, 8/8, 8/10, 8/11, 8/17, and 8/31/2024. RN #2 indicated Resident #61 refused weights at times, the next shift would not obtain the weights since, the resident would have had eaten and fluid therefore causing the weights to be inaccurate. RN #2 further indicated Resident #61 was on contact precautions from 7/29/2024 through 8/10/2024 and may have refused to have her/his weight taken. RN #2 indicated s/he was not aware Resident #61's weights were not always obtained daily and s/he never received information in morning report or any concerns from other staff that weights had not been done. (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	09/11/2024

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

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview and record review with LPN #4 on 9/10/2024 at 8:50 AM indicated 1-2 x per week a nurse aide is not replaced and one of the nurse aides on the unit is moved to another unit to work causing the weight not to be obtained. Resident #61 required 2 people to obtain the weight via a mechanical lift device. LPN #6 further indicated s/he did not notify the 3rd shift supervisor or ask another unit staff member to assist with obtaining weights. An interview on 9/10/2024 at 11:45AM with the supervisor, RN #2 indicated s/he would speak with the staff regarding working together to obtain weights and develop a plan to ensure weights are obtained before breakfast if the 3rd shift is unable get the weight. The facility policy labeled Weight Management dated 6/17/2024 indicated in part, if a resident refuses a weight or if circumstances prevent weighing a resident, the reason is to be documented in the medical record and the weight rescheduled for another time. 3. Resident #120 's diagnoses included emphysema, Chronic Obstructive Pulmonary Disease (COPD), and dementia. The quarterly Minimum Data Set assessment dated [DATE] identified Resident #120 as severely cognitively impaired and required extensive assistance with toileting, was independent with bed mobility and transfers. The Resident Care Plan dated 6/26/24 identified Resident #120 with a potential for pain related to general discomfort. Interventions included to observe daily for discomfort and effectiveness of interventions. However, further clinical record review identified there was no care plan for hospice services identified. A physician's order dated 7/1/24 directed to have Hospice Services evaluate and admit if appropriate As Soon As Possible (ASAP). A nurse's noted dated 7/1/24 at 9:27 PM identified the nurse called Medical Doctor(MD) to request a change in medications. The MD told the nurse to call hospice. The nurse called called the hospice vendor with recommendations from MD. A nurse's note dated 7/2/24 at 1:51 AM identified hospice and the family member was at bedside. Interview and record review with DNS on 9/11/24 at 11:50 AM identified s/he was unable to find any hospice documentation of clinical notes in the clinical record for the hospice evaluation. The DNS also could not explain why the clinical notes for the evaluation was not present. 46046 48792

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	075195	A. Building B. Wing	09/11/2024

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F 0691 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate colostomy, urostomy, or ileostomy care/services for a resident who requires such services. 46046 Based on clinical record review and staff interview for 1 resident (Resident # 19) reviewed for bowel management, the facility failed to consistently change the resident's bowel appliance. The findings include: Resident # 19's diagnoses included schizophrenia, Alzheimer's disease, dementia and dysphagia. The MDS 6/4/24 annual assessment identified the resident as moderately cognitively impaired and noted no functional limitation with upper extremities. Additionally, the assessment noted the utilization of a colostomy. The RCP 7/4/24 for require assistance with ADL. Intervention includes providing physical therapy 5 times a week and occupational therapy 4 times a week. The nurses note 9/4/24 at 5:05 PM identified that Resident # 19 notified the nurse that a nurse aide refused to assist her/him with his/her bowel appliance and the nurse aide also came in turned off the call bell light without seeing what s/he needed. A review of the Treatment Administration Records (TAR) and Medication Administration Record (MAR) for August 15, 2024 to 9/10/24 2024 failed to reflect when Resident # 19 bowel appliance was changed. The nurse's notes dated August 15, 2024 through September 10, 2024 failed to identify when Resident # 19's bowel appliance was changed. Record review and interview with the DNS on 9/10/24 at 11:35 AM identified s/he could not provide evidence when was the last time the resident's bowel appliance was last change from 8/15/24 to 9/10/24. After surveyor inquiry, the DNS updated the TAR to included section to identify when the resident's bowel appliance was last changed.

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	075195	A. Building B. Wing	09/11/2024

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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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48792 Based on review of the clinical record, facility documentation, facility policy and interviews for 1 of 2 residents (Resident #65) reviewed for nutrition, the facility failed to re-weigh resident within 24 hours of a weight change per policy. The findings include: Resident #65 's diagnoses included dysphagia, chronic kidney disease, and gastrointestinal hemorrhage. The admission MDS assessment dated [DATE] identified Resident #65 as moderately cognitively impaired and required maximum assistance with showering, dressing, and indicated the resident was dependent for toileting. A physician's order dated 7/16/24 directed to provide a Consistent Carbohydrate Diet with no added salt, mechanical ground soft texture regular thin liquid consistency. The Resident Care Plan with a revision date of 7/26/24 identified the resident has a nutritional problem or potential for a nutritional problem related to end stage renal disease, GI issues and dysphagia. Interventions included providing diet as ordered, obtain a dietary consult and follow as needed. A Registered Dieticians note dated 7/26/24 at 9:54 AM identified Resident # 65 with multiple hospitalization s in the last 6 months including a prolonged psychiatric stay and recent stay for shortness of breath. Now with weight loss seen. The resident is working with Speech Language Therapist (SLP) for dysphagia management, previously on a puree texture with Nectar Thickened Liquids (NT). The resident has now been upgraded to mechanical software. Appetite/intake are variable but anticipate improvement with diet upgrade. The resident has a pressure injury to coccyx. Will continue with ongoing weekly weights, if any further loss seen, will reevaluate need for oral nutritional supplements or other nutrition intervention. Documentation of Resident # 65's weights as follow: 9/02/2024 10:37 190 Lbs. (Standing) 8/21/2024 22:32 188 Lbs. (Standing) 8/07/2024 20:52 186.2 Lbs. (Standing) 8/07/2024 10:36 186.6 Lbs. (Standing) 7/31/2024 20:30 189.7 Lbs. (Wheelchair) 7/24/2024 20:18 191.5 Lbs. (Wheelchair) 7/19/2024 10:01 191 Lbs. (Wheelchair) (continued on next page)

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	075195	A. Building B. Wing	09/11/2024

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	7/12/2024 21:06 191.8 Lbs. (Wheelchair) 7/05/2024 21:19 214 Lbs. (Mechanical Lift) 5/03/2024 16:12 212.4 Lbs. (Standing) 5/01/2024 22:43 213.8 Lbs. (Standing) 4/05/2024 16:00 216.5 Lbs. (Standing) 4/02/2024 16:28 216.6 Lbs. (Standing) 3/05/2024 15:13 214 Lbs. (Standing) 3/01/2024 07:04 223 Lbs. (Standing) 2/01/2024 15:12 223 Lbs. (Standing) 1/03/2024 10:38 215 Lbs. (Standing) Resident # 65 had a 3 lb or more weight change between 7/5/24 and 7/12/24, 7/31/24 and 8/7/24. Resident # 65 lost weight between 7/26/24 and 8/21/24 and started to gain weight on 9/2/24. Previously, the resident had 3 lb fluctuations in weight 3/1/24 and 3/5/24, 4/5/24 and 5/1/24. There was no documentation or evidence that the resident was re-weighed within 24 hours of the identified weight changes. Interview on 9/10/24 at 8:45 with Registered Dietician identified the resident's baseline weight was in the 190's, and s/he is now back at baseline. Further the dietician considered Resident # 65 weight loss a concern secondary to no weight loss since 7/26/24 which was not significant. The dietician indicated s/he would not order a supplement with amount of weight loss as the resident is still over ideal body weight. Interview and record review with the DNS on 9/9/24 at 1:20 PM. identified the facility practice is for the nurse aide to notify the nurses of the weights obtained so the nurse can review for weight loss The nurse documents the weight in facility medical record software and the expectation is the nurse should look back at the previous weight. As per facility policy if there is a 3 lb. weight change from previous weight, the nurse should re-weigh in 24 hours. The DNS stated there should have been a re-weigh on 7/13/24 as the resident lost 23.8 lbs. The DNS also stated s/he was not sure why the re-weight did not occur. The DNS indicated an agency staff may have been on duty when weights were not obtained for Resident # 65. Review of the Weight Measurement Policy dated 8/17/18 stated in part, weights with a 3-pound gain or loss will be verified within 24 hours.

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	075195	A. Building B. Wing	09/11/2024

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46046 Based on observations, clinical record reviews, review of policy and interviews for 1 of 3 residents (Resident #72) reviewed for Respiratory Care, the facility failed to ensure supplies were available for a resident with specific respiratory needs in the event of an emergency and for 2 of 3 sampled residents (Residents # 79 and Resident # 112) reviewed for respiratory care, the facility failed to ensure the resident's oxygen tubing was dated and labeled in accordance to facility practice. The findings include: 1. Resident #72's diagnosis includes a muscle disorder with generalized muscle weakness, acute respiratory failure with hypoxia (low oxygen) and obstructive sleep apnea. The Registered Nurse (RN) admission note dated 7/31/2024 at 5:03 PM indicated in part Resident #72 had a tracheostomy tube (Trach) capped as tolerated and utilized a non-mechanical ventilator (AVAPS) The admission Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #72 as cognitively intact, tracheostomy (Trach) care and and noted use of a non-invasive mechanical ventilator. The care plan dated 8/12/2024 Resident #72 noted stage 1 wound (non-blanchable redness) on the bridge of the nose. Intervention included: to assist/encourage to apply silicone cover to the nasal bridge under the AVAPS (Average Volume Assured Respiratory Support a Non-Mechanical Ventilator) mask at bedtime. However, further review of clinical record identified no care plan in place regarding Resident #72's tracheostomy or AVAPS use and care. The physician's orders dated 8/30/2024 directed to provide trach care twice daily and as needed for preventative measure. An observation and interview with the supervisor, RN #2 on 9/9/2024 at 2:55 PM identified resident care supplies in bags, boxes and drawers, unorganized and difficult to find supplies if needed in an emergent situation for a resident who utilized a tracheostomy. An Ambu bag was in a clear bag attached to the resident's wheelchair and the two spare tracheostomy needed for emergency replacement took several minutes to locate one tracheostomy among the supplies and various possible locations within the room. An interview with RN #1 on 9/09/2024 at 3:15 PM indicated s/he would have one of the nurses organize the supplies in Resident #72's room and would call the respiratory company for the additional smaller size tracheostomy needed in an emergency. RN #1 indicated s/he would locate in-service training of the licensed staff on how to replace a tracheotomy in an emergency. On 9/9/2024 at 4:15 PM RN #1 indicated s/he had no nurses in serviced regarding the replacement of a tracheostomy in the event of an emergency. RN # 1 indicated s/he would contact the respiratory company to see if they could come in today to train licensed staff. (continued on next page)

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	075195	A. Building B. Wing	09/11/2024

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview with the DNS on 9/9/2024 at 4:40 PM indicated s/he would need to check the staff competencies to see which nurses were qualified to provide tracheostomy care and change a tracheostomy in an emergency and have them be assigned to each shift to the resident. On 9/09/2024 at 4:43 PM RN #1 indicated s/he spoke with the DNS and identified no licensed staff have been trained to replace a tracheostomy in an emergency. RN #1 further indicated the respiratory company would be available to train staff tomorrow morning and the needed tracheostomy will also arrive tomorrow. RN #1 indicated the only option for the facility to correct the current situation was to transfer the resident to the emergency room until all supplies were in the facility and licensed staff trained. The care plan dated 9/9/2024 indicated in part, Resident #79 had altered respiratory status due to difficulty breathing at night. Intervention included: applying the AVAPS at bedtime with the silicone barrier applied on the bridge of nose and daily cleaning of AVAPS. The care plan further indicated Resident #72 had a tracheostomy for breathing due to respiratory failure with interventions included in part to complete trach care as ordered, utilized enhanced barrier precautions, maintain an Ambu bag(to provide artificial respirations by hand) at bedside, replacement tracheostomy tubes of equal and one size smaller at bedside and the respiratory therapist to evaluate, provide interventions as needed or requested, and suction the trach as needed or requested. The facility policy labeled Emergency Tracheostomy Tube Change dated 7/16/2024 indicted in part, the nurse will perform an emergency tracheostomy tube change in the event the tracheostomy tube became displaced or dislodged. The policy further indicated a tracheostomy tube one the same size and one a size smaller should be kept at the bedside of any resident who has a tracheostomy tube. 2. Resident #79 's diagnoses included heart failure, Obstructive and Reflux Uropathy and anxiety. The quarterly Minimum Data Set assessment (MDS) dated [DATE] indicated resident as cognitively impaired and required two person assist with bed mobility and transfers. The care plan dated 4/29/24 identified Resident #79 is non-compliant with keeping her/his oxygen on. Interventions include for staff to replace oxygen on resident as needed and to encouraged resident to keep oxygen on. A physician's order dated 7/15/24 directed to change oxygen tubing & set-up weekly every night shift every Sunday label tubing with date when changed as needed. Observation on 9/04/24 at 10:28 AM identified Resident 79 oxygen canula on the floor and tubing not labeled. Interview with LPN #8 on 9/04/24 at 10:28 AM indicated Resident # 79 pulls out the cannula. LPN # 8 also indicated 11-7 AM shift is responsible for labeling and dating oxygen tubing and indicated s/he was unable to provide explanation why the tubing was not labeled. After surveyor inquiry, the resident's oxygen tubing was changed, dated and initialed. 3. Resident #112 diagnoses included respiratory failure unspecified with hypoxia or hypercapnia, asthma, and cancer. (continued on next page)

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	075195	A. Building B. Wing	09/11/2024

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #112 as intact cognitively and required setup/clean up assistance with oral hygiene, and supervision with toileting, showering, and walking 10 feet. The physician's orders dated 8/22/24 directed Oxygen at 3-4 Liters Per Minute (LPM) via Nasal Cannula (NC) continuously for Desaturation (DeSat) or Shortness Of Breath (SOB). 2 Liters (L) every shift for SOB. The physician's orders dated 8/25/24 directed to Change oxygen tubing & set-up weekly-every night shift every Saturday label tubing with date when change. Change oxygen tubing & set-up weekly as needed Label tubing with date when changed. The Resident Care Plan dated 8/27/2024 identified Resident #112 has emphysema/COPD and uses oxygen. Intervention include to give oxygen therapy as ordered by the physician. The medical note dated 8/26/24 directed to continue oxygen supplement for Resident #112. Observations on 9/04/24 at 1:23PM identified Resident #112 sitting up in bed with nasal cannula in use. Oxygen machine tubing was observed with a date of 8/23. Interview with LPN #2 on 9/04/24 at 2:33PM identified the expectation is for staff to change oxygen tubing every Saturday on night shift, 11 PM-7AM. After surveyor inquiry,oxygen tubing was dated 9/04/24. ___ 49100 50167

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	09/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. 46046 Based on review of facility documentation and staff interviews, the facility failed to ensure nursing staff completed in-servicing and competencies training yearly and failed to ensure annual performance evaluations were completed The findings included: 1,An interview and review of facility documentation on 9/5/2024 at 1:15 PM with RN#1 and the DNS identified the Fear of Retaliation in-servicing for 2023 each staff member received reviewed and signed the fear of retaliation facility policy. However, no training materials were utilized for the training. Documentation was provided for the year of 2024 using the Hand in Hand electronic media and signature sheets. Interview and review of facility documentation with Human Resource (HR) Manager #1 on 9/11/2024 at 1:40 PM indicated 1 of 3 nurse aides (NA#9) and 2 of 3 LPN's (LPN #10 and #11) and 2 of 2 RN's randomly reviewed for completed performance evaluations and had no performance evaluations completed based on dates of hire from 8/1/2005 through 8/9/2018. HR Manager #1 further indicated s/he not know why the evaluation were not completed and found. 2. On 9/11/2024 an interview with RN #1 at 1:15 PM identified the facility was unable to provide evidence of nurse aide competencies related to providing care and licensed nurse competencies providing care other than IV therapy, Tracheostomy and changing a tracheostomy.

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	075195	A. Building B. Wing	09/11/2024

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

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49100 Based on review of the clinical record, facility documentation and interviews for 1 resident (Resident# 422) reviewed for Unnecessary Medication, the facility failed to promote the resident psychosocial well-being by when the resident missing property could not be located timely. The findings include: Resident #422 's diagnoses included hypertension, dysphagia and cognitive communication defect. The care plan dated 7/25/24 identified Resident #422 had psychosocial wellbeing problem related admission. Interventions include to give positive reinforcement and attempt to resolve conflicts. A physician's order dated 7/25/24 indicated to monitor for sudden changes in behaviors. The quarterly Minimum Data Set assessment dated [DATE] indicated Resident #422 was cognitively intact and requires require supervision/ touching assistance for bed mobility. A review of facility documentation identified on 8/4/24 Resident # 422 reported to staff s/he could not find his/her wallet but thought s/he had left her/his wallet with a family member. Interview with DNS on 9/5/24 at 3:15 PM indicated Residents #422 wallet was in a closet in the nursing supervisor's office. The DNS indicated s/he did not believe staff expected the wallet to be there. She further explained residents' items are usually stored in the supervisor's office or in the business office, however, s/he the DNS believes staff might have missed the wallet during their initial search. On 9/10/24 during review of staffs written investigation statement identified no staff reported having searched the Nursing Supervisor's closet. Interview with Resident #422 on 9/10/24 at 8:40 AM s/he had received his/her wallet with all contents in it. However, the resident expressed s/he felt overwhelmed and stressed during the incident and had to cancel all credits cards and obtain new ones with a new identification card. Interview with RN#1 9/10/24 indicated the expectation is staff should have searched the nursing office have been searched as a place for storage of resident's items.

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	075195	A. Building B. Wing	09/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Parkway Pavilion Health and Rehabilitation Center	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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37721 Based on clinical record reviews, facility documentation, facility policy and interviews for 1 of 2 sampled residents (Resident #173) reviewed for hospice, the facility failed to ensure the provision of routine and emergency pain medication for a resident receiving end of life services/ Hospice. The findings include: Resident #173's diagnoses included pancreatic cancer and diabetes mellitus, type II and receiving end of of life services. The findings include: The Nursing Admission assessment dated [DATE] identified Resident #173 was admitted from home, was alert and oriented, independent with self-care and did not report any pain. The facsimile Medication Order Report dated 6/4/23 received from the community hospice center identified Resident #173 had medications orders that included acetaminophen tablet 325 MG by mouth every 4 hours as needed for Pain/Elevated Temperature greater than 101 Do not exceed 3 GM in 24 hours, Morphine Sulfate (concentrate) solution 20 MG/ML. Give 0.25 ml by mouth every 3 hours as needed for pain and, Fentanyl patch 12 MCG/HR. Apply 1 patch transdermal every 72 hours for pain. The Order Report further noted the Fentanyl patch was due to be changed on Tuesday (6/6/23). The physician's orders dated 6/4/23 directed medications that included acetaminophen tablet 325 MG by mouth every 4 hours as needed for Pain/Elevated Temperature greater than 101 Do not exceed 3 GM in 24 hours, Morphine Sulfate (concentrate) solution 20 MG/ML. Give 0.25 ml by mouth every 3 hours as needed for pain and, Fentanyl patch 12 MCG/HR. Apply 1 patch transdermal every 72 hours for pain. A nurse's note dated 6/4/23 at 8:21 PM identified Resident #173 arrived at the facility at 4:30 PM from home with the responsible party for respite care. Resident #173 was alert and verbal, denied pain or discomfort. Physician's orders were verified. Resident #173 was in bed with the responsible party at bedside. The Resident Care Plan dated 6/5/23 identified Resident #173 was receiving end of life services, a potential for pain and activity of daily living deficit. Interventions directed comfort measures, administer pain medication as needed and explain all procedures before starting. The Medication Administration Record (MAR) dated 6/4/23 through 6/8/23 identified on 6/6/23 at 9:00 AM, Resident #173 was scheduled to receive a new Fentanyl patch 12 MCG/HR transdermal. The MAR was signed by Licensed Practical Nurse, LPN #5 and directed to refer to the nurse note. A nurse's note dated 6/6/23 at 1:24 PM identified the facility was awaiting delivery and the nursing supervisor was notified that the medication was unavailable. The pharmacy receipts dated 6/4/23 through 6/8/24 did not include Morphine Sulfate (concentrate) solution 20 MG/ML and Fentanyl 12 MCG/HR patches. (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	09/11/2024

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

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility list for Emergency Controlled medications identified Morphine Sulfate (concentrate) solution 100 MG/5 ML and Fentanyl 12 MCG/HR patches were available in the facility for use during that time. The facility was unable to provide documentation and or evidence the Fentanyl Patch or Morphine concentrate ordered from the pharmacy at any time during Resident #173's stay and was removed from the emergency controlled medications box to administer to Resident #173 after learning it was unavailable. An interview with the Director of Nursing Services, DNS on 9/9/24 at 9:32 AM identified although s/he was not employed at the facility at the time of the occurrence, s/he determined the medication was never received from the pharmacy. The DNS identified s/he would expect nursing staff to obtain the medication from the emergency controlled medications box if unavailable at the time of administration. An interview with the Medical Director on 9/9/24 at 10:12 AM identified for any prescriptions for controlled drugs, the nursing staff would fill out the prescription slip. He/she would sign the prescription and forward it to the pharmacy to be filled. The Medical Director identified that although s/he could not recall the resident or incident, s/he would have signed the prescription if sent by the nursing staff. The Medical Director further identified s/he would expect a resident to receive all medications as ordered. An interview with LPN #5 on 9/9/24 at 10:23 AM identified she was the assigned charge nurse on 6/6/23 during the 7:00 AM to 3:00 PM shift when Resident #173 was due to receive a new Fentanyl patch. LPN #5 identified that although s/he could not recall the incident, LPN# 5 would notify the nursing supervisor and request the medication be obtained from the emergency controlled medications box and then notify the pharmacy to determine the status of the medication. An interview with Registered Nurse, RN #4 on 9/9/24 at 10:28 AM s/he was one of two nursing supervisors assigned on 6/6/23 during the 7:00 AM to 3:00 PM shift. RN #4 identified that although s/he was unable to recall the resident or incident, s/he would first check availability of medications in the emergency controlled medications box and then contact the pharmacy for any controlled medication that was unavailable at the time of administration. An interview with the Director of PharMerica identified there was no record that prescriptions for Morphine Sulfate (concentrate) solution 20 MG/1 ML and Fentanyl 12 MCG/HR patches were sent to the pharmacy for Resident #173 between 6/4/23 and 6/8/23. A review of the facility policy for Medication and Treatment Orders dated 7/2016 directed that medications shall be administered only upon written order of the person duly licensed and authorized to prescribe such medications. Only authorized personnel will call in orders for prescribed medications to the pharmacy. Although requested, a policy for the availability and use of emergency controlled medications were not provided. Attempts to interview RN #3, the 2nd assigned Nursing Supervisor on 6/6/23 and RN #7, the assigned nurse on 6/4/23 were unsuccessful.

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	075195	A. Building B. Wing	09/11/2024

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46046 Based on review of the clinical records, facility documents, review of facility policy and staff interviews for 4 of 6 residents reviewed for Medication Regimen Review and Unnecessary Medications (Residents #6, #22 #65, and #103), the facility failed to ensure pharmacy recommendations were addressed by the physician timely. The findings included. 1. Resident #6 's diagnoses included unspecified psychosis, unspecified dementia, and depression. A quarterly MDS assessment dated [DATE] identified Resident #6 had severe cognitive impairment and required supervision or touching assistance for transferring from bed to chair. a. On 9/10/2024, a sample of pharmacy recommendations for Resident #6 was reviewed and identified the following: The pharmacy recommendation dated 9/30/23 indicated Resident #6 had two orders for Acetaminophen (Tylenol), which may be considered duplicate therapy and recommended that one of the orders be discontinued. The pharmacy recommendation form did not contain a physician's response or signature to the recommendation. Additionally, a review of the physician's orders identified the duplicate Acetaminophen order was discontinued on 2/17/2024, which was 4 months and 18 days after the recommendation was made by the pharmacy. b. A pharmacy recommendation dated 1/24/2024 indicated Resident #6 was receiving a statin (a medication for high cholesterol) and a recommendation was made for baseline and annual bloodwork for lipid monitoring be ordered. The pharmacy recommendation form did not have a physician's response or signature. The same recommendation was repeated by the pharmacy on the pharmacy recommendations dated 2/20/2024 and 3/23/2024. Additionally, the pharmacy recommendation forms for 2/20/2024 and 3/23/2024 did not have a physician response or signature to the recommendations. A review of laboratory results identified bloodwork to test for lipid levels was collected on 3/28/2024, which was two months after the initial recommendation by the pharmacy. On 9/11/24 at 10:51 AM, an interview with the Assistant Director of Nursing Services (ADNS) indicated pharmacy recommendations are faxed or emailed to the facility. The facility then prints and sorts the recommendations by provider/practitioner. However, there was no tracking system to determine if providers had addressed the recommendations. 2. Resident #22 's diagnoses included vascular dementia, hyperlipidemia and type 2 diabetes mellitus. A physician's order dated 4/19/24 directed to give 1 tablet (Lorazepam oral tablet 0.5MG) by mouth every 4 hours as needed. A pharmacy consults on 5/20/24 recommendation indicated Please evaluate current diagnosis, behavior usage patterns and evaluation continued need. When needed psychotropic orders cannot exceed 14 days with the exception prescriber documents their rational in the residents' medical records. (continued on next page)

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	075195	A. Building B. Wing	09/11/2024

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Pharmacy recommendation identified recommendation by pharmacy had not been reviewed or signed by the physician to identify if the physician agreed or disagreed with the recommendation. On 6/28/24 the recommendation was discontinued. The quarterly Minimum Data Set assessment dated [DATE] indicated Resident #22 as cognitively impaired and dependent on staff for in eating, oral hygiene and bed mobility. The care plan dated 8/1/24 identified Resident #22 uses anti-anxiety medications related to restlessness. Interventions include to give anti-anxiety medications ordered by physician. Monitor and document side effects and effectiveness Interview with Pharmacy Consultant #1 on 9/11/24 at 9:35 AM indicated if they notice the facility has not followed up on a recommendation, pharmacist will made a second recommendation and speak to the facility regarding their recommendations. Interview with ADNS on 9/11/24 at 10:51 AM reported, recommendations get faxed or emailed to DNS, ADNS and nursing supervisor then print and sort recommendations by practitioner. The ADNS and nursing supervisors would take care of any nursing recommendations. The ADNS reports the facility do not have a system in place for tracking if pharmacy recommendations were followed through with in a timely manner. Review of the Medication Regimen Review and Reporting policy dated 1/24 directed, in part, recommendations should be acted upon within 30 calendar days or per facility specific protocols. 3. Resident #65's diagnoses included Bipolar disorder, Schizophrenia, and gastrointestinal hemorrhage. A physician's order dated 10/9/23 directed to administer Linzess Oral Capsule 290 mcg one time per day for constipation. A pharmacy note dated 4/23/24 written by Consultant Pharmacist #1 recommended that Linzess be administered before meals as opposed to 8:00 AM. The admission minimum Data Set assessment dated [DATE] identified Resident #65 as moderately cognitively impaired and required maximum assistance with showering, dressing, and was dependent for toileting. The Resident Care Plan with a revision date of 7/26/24 identified the resident had a potential for constipation. Interventions included to provide diet as ordered, and to encourage fluids. There is no evidence that the pharmacist recommendation was followed up on until 7/25/24 after surveyor inquiry. However, review of the Medication Administration Record for August 1, through 31,2024, and September 1 to 10, 2024, indicate the resident's Linzess Oral Capsule 290 mcg one time per day for constipation was administered at 8:00 AM daily. (continued on next page)

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	075195	A. Building B. Wing	09/11/2024

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with the ADNS on 9/11/24 at 10:51 AM identified the pharmacist's recommendations get faxed or emailed to the DNS. The ADNS and nursing supervisor print the report and sort them by practitioner and nursing. The ADNS and supervisor follow up on all nursing recommendations. 4. Resident #103's diagnosis include heart failure, hypertension, chronic kidney disease, and history of a pulmonary embolism. The annual Minimum Data Set (MDS) dated [DATE] indicated Resident #103 as cognitively intact, received in part anticoagulant, diuretic, and antiplatelet medication. The care plan dated 8/22/2024 indicated resident #103 had a cardiovascular problem. Intervention included: to administer medications as order and provide the diet as ordered and to monitor meal consumption. The care plan further indicated Resident #103 was on anticoagulant therapy with interventions including in part added to the care plan on 6/10/2024 to observe/document/report to MD and signs of bleeding. The care plan initiated 9/10/2024 indicated Resident #103 was on diuretic therapy related to heart failure. Interventions included to administer medications as ordered and to observe for postural hypotension and possible side effects and inform the physician. a. A pharmacy consultant recommendation form labeled Note To Attending Physician/ Prescriber dated 10/27/2023 indicated Resident #103's blood pressure/pulse was generally stable and further indicated to please consider discontinuation of parameters on lisinopril and metoprolol and reduce monitoring weekly on the Medication Administration Record (MAR). The physician/prescriber Response area of the form was not completed by the physician. The same recommendation was issued on 11/22/2023. The physician responded in agreement, signed and dated the form 12/6/2023 (41 days after the initial recommendation). b. A pharmacy High Risk Medication Monitoring recommendation printed on 1/24/2024 indicated Resident #103 was on and anticoagulant Eliquis and indicated the resident should be monitored for signs/symptoms of bleeding/bruising and thromboembolism. The response area of the form was not completed by the physician. The same recommendation was written dated 2/20/2024 with no response written by the physician. No other medication recommendations were provided but a physician's order was added on 5/28/2024 to monitor for signs and symptoms of bleeding bruising and thromboembolism (125 days after the initial pharmacy recommendation). c. A High-Risk Medication Monitoring recommendation with printed date of 1/24/2024 indicated Resident #103 Is taking a diuretic: Torsemide and recommended monitoring for signs and symptoms of dehydration, electrolytes, acute kidney injury, monitor for edema, congestion and weight changes. The response area was not completed by the physician and a second recommendation was made on 2/20/2024 with no physician/prescriber response (28 days after the initial pharmacy recommendation). After surveyor inquiry, a physician order was obtained (no signed pharmacy recommendation response form provided) on 9/9/2024 at 11:27 AM directing to monitor for signs and symptoms of dehydration, electrolytes per MD orders, acute kidney injury, monitor for edema, congestion and weight changes every shift related to heart failure and unspecified kidney disease (230 days after the initial pharmacy recommendation was made). (continued on next page)

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	075195	A. Building B. Wing	09/11/2024

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

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview with the ADNS on 9/9/2024 at 11:37 AM after receiving incomplete recommendation requests for Resident #103, the ADNS identified s/he did not know why the forms were not completed/signed by the physician/prescriber timely and placed the forms in the resident's charts. The ADNS indicated the pharmacy consultant monthly visits are kept in binders and the recommendations are provided to the physician/prescribers. An interview with the Pharmacy Consultant #1 on 9/11/2024 at 9:35 AM indicated the facility had verbally responded to some of the recommendations by saying the information was in the care plan after the second recommendation which seemed acceptable. Pharmacy Consultant #1 further indicated her/his usual practice after not obtaining a response from the initial recommendation a second recommendation would be made in addition to speaking with the staff. The facility policy labeled Medication Regimen Review and Reporting dated 7/16/2024 indicated in part Resident-specific medication Regimen review recommendations and findings are documented and acted upon by nursing and or the physician and follows up on the recommendations are verified for appropriate action taken within 30 calendar days. 48880 49100

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	075195	A. Building B. Wing	09/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49100 Based on review of the clinical record, facility policy and interviews for 1 of 6 residents reviewed for Unnecessary Medication, the facility failed to order as needed (PRN) psychotropic medications for only 14 days. The findings include: Resident #22 's diagnoses included vascular dementia, hyperlipidemia and type 2 diabetes mellitus. The quarterly Minimum Data Set assessment dated [DATE] indicated Resident #22 as cognitively impaired and dependent on staff with eating, oral hygiene and bed mobility. The care plan dated 8/1/24 identified Resident #22 uses anti-anxiety medications related to restlessness. Interventions include to give anti-anxiety medications ordered by physician. Monitor and document side effects and effectiveness. A physician's order dated 8/21/24 directed to give 1 tablet (Lorazepam oral tablet 0.5MG) by mouth every 4 hours as needed for anxiety/restlessness for 30 Days. The Medication Administration Records indicated Resident #22 last received the Lorazepam on 9/7/24. Interview with the Advanced Practice Registered Nurse (APRN #1) on 9/10/24 at 12:11 PM identified if a resident is on a controlled medication, the resident should only be on it for 14 days and then re-assessed to determine if they still need the medication. S/he further indicated there are no 14 limits for residents who are on hospice (i.e. Resident #22). Interview with Pharmacy Consultant #1 on 9/11/24 at 9:35 AM indicated if the pharmacy notice the facility has not followed up on a recommendation, they write their recommendation twice and speak to the facility regarding the recommendations.

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	075195	A. Building B. Wing	09/11/2024

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 48880 Based on observations and staff interviews for 1 of 2 medication rooms and 2 of 3 medication carts reviewed for medication storage, the facility failed to ensure that medications were labeled appropriately and stored in a clean and sanitary environment. The findings include: 1. On 9/4/2024 at 11:05 AM observation of the East Medication Room and medication refrigerator with LPN #8. The following was observed the medication refrigerator appeared visibly soiled. There was brown, flaky residue on the back left side of the lower shelf where one box of Omeprazole oral suspension and three 150 ml bottles of Vancomycin oral solution were stored. There were two clear drawers under the bottom shelf that had brown and pink residue. Due to the sticky pink residue, the right side drawer was difficult to open as it was stuck to the lower portion of the refrigerator. The bottom shelf inside the refrigerator door also had pink, brown, and white residue. The inside of the door also had brown and pink residue on it. 2. The medication refrigerator also had a top freezer. The freezer was noted to be visibly soiled. There were red and yellow sticky residue on the lower portion of the freezer. There were three unopened vanilla ice cream cups without resident labels on the shelf of the freezer. There were also three frozen plastic water bottles two of which were half empty. An interview with LPN #8 indicated s/he did not know what the residue in the refrigerator was and how long it had been present. LPN #8 also indicated that housekeeping cleans the floor and counters of the medication room but not the refrigerator. LPN #8 further indicated the ice cream cups were probably for residents but that ice creams are stored in the freezer of the nourishment room located down the hall. 3. On 9/4/2024 at 11:55 AM, the medication cart E.N. Medication Cart during observation with LPN #8 identified three gray-colored nail clippers were stored in the upper right drawer of the medication cart. There was also a 7.5 ml COVID-19 antigen reagent bottle with an expiration date of 2/2024. In the bottom drawer of the medication cart, there were two aerosol air fresheners. LPN#8 indicated the nail clippers should be stored in the treatment cart, that the COVID-19 reagent should not be stored in the medication cart, and the supplies for COVID testing are usually obtained from Staff Development or the supervisor. Additionally, LPN #8 indicated she did not know why aerosol air fresheners were being stored in the medication cart. 3. On 9/4/2024 at 12:50 PM, observation and interview with the nursing supervisor (RN #2) indicated the medication refrigerator should be clean. R.N. # 2 indicated that the ice cream was for residents and that the frozen water bottles may have been used when the ice machine had been out of service. (continued on next page)

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	075195	A. Building B. Wing	09/11/2024

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	4. On 9/4/2024 at 12:55 PM the medication cart T.C. North Medicaiton Cart during observation with LPN # 6 identified multidose vial of Lidocaine 1% (a local anesthetic) containing clear liquid was stored in the upper right drawer of the medication cart. The vial did not have a top cover. The vial was not labeled with a resident's name or the date on which it was opened. The expiration date on the vial was 7/2026. LPN #6 indicated s/he was not sure what the lidocaine was being used for. .On 9/11/24 at 10:55 AM, an interview with the Environmental Healthcare Services Account Manager (Housekeeping Director) indicated that cleaning the medication refrigerator was not a routine part of housekeeping. The housekeeping Director indicated the medication room is cleaned every day except for the refrigerator. The Housekeeping Director further indicated that nurses will call if the refrigerator needed cleaning and that nurses would remove all the medications from the refrigerator so that housekeeping could clean. The Housekeeping Director did not know when the last time that the East Medication Room refrigerator was cleaned prior to the state survey. On 09/11/24 at 11:20 AM an interview with the DNS indicated housekeeping is responsible for cleaning the medication refrigerators and that food should not be stored in the medication room. The facility policy for Medication Storage notes medications should be stored separately from food. Additionally, the policy identified that nursing staff was responsible for maintaining medication storage and preparation areas in a clean, safe, and sanitary manner. The policy also indicated that drug containers with missing, incomplete, improper, or incorrect labels should be returned to the pharmacy for proper labeling before storage.

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	075195	A. Building B. Wing	09/11/2024

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 48950 Based on the tour of the Dietary Department/Nourishment Rooms, review of policy and staff interview, the facility failed to ensure the Dietary department was maintained in a clean, sanitary manner. The findings included: Tour of the Dietary Department on 9/4/2024 at 10:07 AM during the initial walk through of the kitchen with the Dietary Manager (DM) identified the following: (see photos) a. The ceiling in the kitchen was identified to be discolored and had grayish, brown hanging substance noted around the lights and duct work. b. Tour of the Central Nourishment Rooms on 9/4/24 at 10:15 AM with the Dietary Director and Housekeeping Director identified: a resident's ice pack for personal use in the freezer Discolored red substance noted along the shelves Brown substance inside the shelves on the doors c. Tour of the East Wing Nourishment Rooms on 9/4/24 at 10:38 AM with the Dietary Director and Housekeeping Director identified: Brown substance noted to the shelves inside the refrigerator and along the shelves on the doors. A bag which contained 3 bowls with personal food items, not labeled or dated which had freezer burn noted to each item. A bowl of cereal on the counter which was not labeled or dated. d. Tour of the TCU Nourishment Rooms on 9/4/24 at 10:51 AM with the Dietary Director and Housekeeping Director identified: A turkey sandwich in the refrigerator that was not dated 2 packages of crackers on the floor The floor outside the refrigerators was sticky Interview on 9/4/24 at 10:50 AM Director of Housekeeping and the Director of Dietary who identified the Dietary department is responsible for cleaning the refrigerators and that Housekeeping is responsible for cleaning the Nourishment rooms. They also identified that personal food items are not to be kept in the Nourishment Room refrigerators, items needed to be labeled and dated, food should not be left on the floor, and the refrigerators were not clean. (continued on next page)

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	075195	A. Building B. Wing	09/11/2024

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Interview on 9/04/24 at 12:00 PM Dietary Manager identified the ceilings in the kitchen were not clean, stating maybe the ceiling need to be painted or clean and that s/he had notified maintenance, but the Maintenance Director was leaving her/his position in about a week. Interview on 9/4/24 at 1:17 PM with the Maintenance Director identified s/he was probably responsible for cleaning the ceiling and the substance noted on the ceiling was dust after getting on a ladder and swiping it with his/her finger. S/he also stating ceiling needed a good cleaning and identifying that housekeeping is responsible for cleaning the it. An interview on 9/4/24 at 1:21 PM with the Housekeeping Director identified that housekeeping was only responsible for cleaning the floors. The Dietary Director stated that s/he would take responsibility for making sure the cleaning would be completed. The facility policy for Nourishment Kitchen notes once daily or as directed, the assigned dietary staff member will ensure all provided items are labeled and dated per the facility Date Marking Policy and discarded if unlabeled and dated. The policy also identified that dietary staff was responsible to clean any observed spills and sanitize the cleaned area.

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	075195	A. Building B. Wing	09/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Dispose of garbage and refuse properly. 48950 Based on observations of the dumpster and interviews, the facility failed to properly dispose of garbage and refuse. The findings include: Observation made with the Dietary Director, Maintenance Director, and Environmental Director on 9/4/24 at 10:18AM of the dumpsters identified numerous debris left alongside of the dumpsters and facility which included a discarded mattress with a brown substance noted on the cover, multiple used gloves, discarded cigarette buds, plastic cups, bags, and bottles. On 9/4/24 at 10:18AM an interview with the Dietary Director identified the area was not well kept or cleaned and s/he was unsure of who was responsible for maintaining the area around the dumpsters. On 9/4/24 at 10:20 AM an interview with the Maintenance Director identified the dumpsters are emptied 2 times a week. The Maintenance Director also identified that's s/he was unsure of who was responsible for maintaining the area around the dumpsters. On 9/04/24 at 2:23 PM an interview with RN #1 identified all the staff were responsible for picking up around the dumpsters. and there is no policy at the present time. On 9/05/24 at 9:33 AM an interview with the DNS identified there were some residents in the facility that were able to go outside independently on the grounds. After surveyor's inquiry, the area around the dumpsters was cleaned up.

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	075195	A. Building B. Wing	09/11/2024

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F 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly 46046 Based on review of facility documentation and interview, the facility failed to ensure QAPI meetings were conducted at least quarterly, and a Performance Improvement Plan (PIP) completed annually. The findings include: An interview with the Administrator, the DNS and RN #1 on 9/11/2024 at 2:33 PM identified they were unable to provide evidence of a QAPI meeting from October 2023 through February 15, 2024, and was unable to provide evidence that a PIP performed annually in 2022, 2023 or 2024. The Administrator indicated s/he was not at the facility at the time indicated therefore cannot answer why it was done. The Administrator since then the facility have conducted QAPI meetings almost every month and would be conducting a PIP in the near future. The facility policy Quality Assurance and Performance improvement (QAPI) Program indicated in part prioritizing identified quality issues based on risk of h arm and frequency of occurrence and determining which will become a focus of PIP's is an action step of the process.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48792 Based on clinical record review, observation, facility policy and staff interviews for 1 resident reviewed for 1 resident (Resident #72) reviewed for tracheostomy care, the staff failed to implement appropriate infection control techniques for enhanced barrier precautions for the resident. The findings include: Resident #72's diagnoses included Myotonic Muscular Dystrophy, acute respiratory failure, and muscle weakness. The admission Minimum Data Set assessment dated [DATE] identified Resident #72 as cognitively intact and required maximum assistance for toileting, showering, and dressing. A physician's order dated 8/30/24 directed to provide tracheostomy care two times daily. The Resident Care Plan dated 9/9/2024 identified the resident was on enhanced barrier precautions related to tracheostomy care. Interventions included for the staff to wear gown and gloves while caring for the resident and to follow facility policies for enhanced barrier precautions. Observed tracheostomy care on 9/9/24 at 10:15 AM with LPN #3 identified LPN # 3 gathered supplies, gloved and started to remove dressing, Surveyor intervened and asked her/him if the resident was on enhanced barrier precautions (EBP) as the sign indicated outside the door. LPN # 3 said he/she Resident # 72 was not but instead it was (resident is in a 2 bed-room), when asked if s/he should confirm LPN# 3 stated s/he would check with the supervisor. LPN # 3 proceeded to complete the dressing change. Changed gloves in between clean and dirty dressing. Disposed of dirty dressing appropriately. Once outside of room, surveyor showed LPN # 3 the sign. S/he said s/he would call the supervisor. LPN # 3 placed the call to Supervisor RN#2 to confirmed if the resident was on EBP. Interview with RN#1 on 9/9/24 at 2:30 PM RN#1 identified residents on EBP have a letter on the sign outside of the resident's room door, A is door, B is Window. The nurse should have looked at the sign to determine if it was the resident which resident s/he was performing tracheostomy care on. Additionally, RN # 1 indicated there is also a list of residents on EBP on the unit as well. Observation of the signage outside Resident #72's room on 9/9/24 at 2:45 PM indicated EHB was for Resident B. Although requested, a facility policy for Enhanced Barrier Precautions was not provided, however a generic information on Enhanced Barrier Precautions was provided which directed in part, caring for a resident requiring tracheostomy care should be on precautions.

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Keep all essential equipment working safely. 46046 Based on observation, facility policy and interview, the failed to ensure the Automated Emergency Defibrillator (AED) equipment pads were not outdated. The findings include. On 9/05/24 at 1:39 PM Building and Fire Safety Investigator indicated the AED on the center unit in the facility was serviced appropriately and safe, but the pads were outdated and were changed by the facility. On 9/10/24 at 8:40 AM an interview and observation with the DNS identified the AED on the center unit with pads dated 6/8/2025 as the outdated pads noted prior were replaced. During observation the DNS indicated the AED on the TCU unit was new 3 months ago with noted pad dates 6/24/2025. The DNS also indicated although any nurse can check the AED and pads for the expiration date there was no process was in place and no documentation for checking for expiration dates of the pads. The facility policy and procedure labeled Automatic External Defibrillator, Use and Care notes to keep a spare battery and adhesive pads in the case as instructed, record expiration date of the battery and the pads on the maintenance tag or log, and store with device. The facility policy further indicated to check the device and perform maintenance tasks as directed including document checks, maintenance steps and date performed on the maintenance log and store log with the device. A copy of the AED manual was requested but not provided.

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F 0940 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop, implement, and/or maintain an effective training program for all new and existing staff members. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46046 Based on clinical record review, observations, review of facility policy and staff interviews for 1 of 3 residents (#72) reviewed for Respiratory Care, the facility failed to ensure licensed staff were trained to provide an emergency procedure for a resident requiring specialized care. The findings include: Resident #72's diagnosis includes a muscle disorder with generalized muscle weakness, acute respiratory failure with hypoxia (low oxygen) and obstructive sleep apnea. The Registered Nurse (RN) admission note dated 7/31/2024 at 5:03 PM indicated in part Resident #72 had a tracheostomy tube (Trach) capped as tolerated and utilized a non-mechanical ventilator (AVAPS) The admission Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #72 as cognitively intact, tracheostomy (Trach) care and and noted use of a non-invasive mechanical ventilator. The care plan dated 8/12/2024 Resident #72 noted stage 1 wound (non-blanchable redness) on the bridge of the nose. Intervention included: to assist/encourage to apply silicone cover to the nasal bridge under the AVAPS (Average Volume Assured Respiratory Support a Non-Mechanical Ventilator) mask at bedtime. However, further review of clinical record identified no care plan in place regarding Resident #72's tracheostomy or AVAPS use and care. The physician's orders dated 8/30/2024 directed to provide tracheostomy care twice daily and as needed for preventative measure. An observation and interview with the supervisor, RN #2 on 9/9/2024 at 2:55 PM identified resident care supplies in bags, boxes and drawers, unorganized and difficult to find supplies if needed in an emergent situation for a resident who utilized a tracheostomy. An Ambu bag was in a clear bag attached to the resident's wheelchair and the two spare tracheostomy needed for emergency replacement took several minutes to locate one tracheostomy among the supplies and various possible locations within the room. An interview with RN #1 on 9/09/2024 at 3:15 PM indicated s/he would have one of the nurses organize the supplies in Resident #72's room and would call the respiratory company for the additional smaller size tracheostomy needed in an emergency. RN #1 indicated s/he would locate in-service training of the licensed staff on how to replace a tracheostomy in an emergency. On 9/9/2024 at 4:15 PM RN #1 indicated s/he had no nurses in serviced regarding the replacement of a tracheostomy in the event of an emergency but s/he would contact the respiratory company to see if they could come in this day to train licensed staff. An interview with the DNS on 9/9/2024 at 4:40 PM indicated s/he would need to check the competencies to see which nurses were qualified to provide tracheostomy care and change a tracheostomy in an emergency and ensure the resident was assigned on each shift to the appropriate staff. (continued on next page)

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F 0940 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/09/2024 at 4:43 PM RN #1 indicated after speaking with the DNS there was no licensed staff that had been trained to replace a tracheostomy in an emergency. RN #1 further indicated the respiratory company would be available to train staff in the morning and provide needed tracheostomy supply tomorrow. RN #1 indicated the only option for the facility to correct the current situation was to transfer Resident # 72 to the emergency room until all supplies were in the facility and licensed staff trained to care for the resident in an emergency situation. On 9/10/2024 at 12:40 PM RN #1 indicated training was provided at 10:00 AM by the respiratory company and trainers will train the remainder of the staff coming on duty until all staff are trained. RN #1 further indicated the smaller size tracheostomy would arrive later today, and the resident would then return to the facility. RN #1 provided documentation of the training provided. Observation on 9/11/24 identifed Resident # 72 had returned to the facility with appropriate tracheostomy supplies for an emergency and staff had been trained to provide tracheostomy care. The facility policy labeled Emergency Tracheostomy Tube Change dated 7/16/2024 indicted in part the nurse would perform an emergency tracheostomy tube change in the event the trach tube became displaced or dislodged. The policy further indicated a tracheostomy tube one the same size and one a size smaller should be kept at the bedside of any resident who has a tracheostomy tube.

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. 46046 8Based on review of the facility annual training for Nurse Aides, facility documentation and interview, the facility failed to ensure the required 12 hours Nurse Aide training was completed. The findings include: An interview with the DNS on 9/11/2024 at 12:30 PM indicated there had been Nurse Aide training but the Staff Development Nurse who was responsible for the training is no longer employed by the facility. The DNS also indicated s/he could not provide evidence of the facility's annual 12 hours of in-service hours for 2024 because/he could not locate the training.