

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 075250	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/19/2024
NAME OF PROVIDER OR SUPPLIER Parkville Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 5 Greenwood Street Hartford, CT 06106	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record reviews, facility documentation, facility policy and interviews for one (1) of three (3) sampled residents (Resident #1) who were reviewed for an allegation of staff to resident verbal abuse, the facility failed to report an allegation of abuse to the State Agency when the incident was reported to the facility pending the investigation. The findings include:</p> <p>Resident #1's diagnoses included Cerebral palsy, anxiety, depression, and disruptive mood disorder.</p> <p>The annual Minimum Data Set assessment dated [DATE] identified Resident #1 rarely or never made decisions regarding tasks of daily life, was independent with ambulating, transferring, and required set up for dressing and eating.</p> <p>The Resident Care Plan dated 10/31/24 identified observe for signs of anxiety. Interventions directed at identifying triggers, approach calmly, encourage diversional activities.</p> <p>The nurse's note dated 10/24/24 at 8:59 PM identified Resident #1 was transferred to the hospital after he/she became very verbally and physically aggressive towards other residents, staff, and a family member.</p> <p>Correspondence to the facility dated 11/14/24 at 8:25 AM identified an accusation of verbal staff abuse on 10/24/24. The documentation identified information was reported that a nurse aide went through the hallway towards the front desk verbalizing if you don't get him/ her the f**k out of here I'm going to leave. The information indicated several residents, visitors, and staff had witnessed this unprofessional behavior.</p> <p>A Reportable Event had not been submitted to the state agency as per policy.</p> <p>In an interview with the Director of Nursing (DON) on 12/19/24 at 10:00 AM identified on 11/13/24 she was made aware of the alleged staff to resident verbal abuse following the incident with Resident #1 on 10/24/24. The DON stated she investigated the allegation with statements and could not substantiate the allegation, and therefore did not report the incident as per policy.</p> <p>Review of the abuse policy dated 3/20/24 identified all allegations of abuse will be reported promptly and thoroughly investigated.</p>

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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