STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075250	A. Building B. Wing	06/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Parkville Care Center	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)
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record reviews, review of facility documentation and interviews for one (1) of three (3) sampled residents (Resident #1) reviewed for a leave of absence, the facility failed to ensure a nurse reviewed the resident's medications and directions for use that were packaged by the pharmacy prior to giving the medications to the resident and responsible party who was leaving the facility on a leave of absence. The findings include: Resident #1's diagnoses included transient ischemic attack, cerebral infarction without residual effects, adjustment disorder with mixed anxiety and depressed mood, and atherosclerosis of the renal artery. The quarterly Minimum Data Set assessment dated [DATE] identified Resident #1 had a Brief Interview for Mental Status (BIMS) score of twelve (12) indicating Resident #1 had some memory recall deficits. The nurse's note dated 5/2/26 at 3:44 PM identified Resident #1 went on a leave of absence (LOA) with family. The pharmacy packing slip signed by the 11PM-7AM charge nurse, LPN #2, on 5/2/26 identified the following medications were received by the facility for Resident #1 to take on the leave of absence: two (2) 80 milligram (mg) tablets of atorvastatin, two (2) 25 mg tablets of Chlorthalidone, two (2) 75 mg tablets of Clopidogrel, four (4) 25 mg tablets of carvedilol, two (2) 1 mg tablets of folic acid, two (2) 90 mg tablets of Nifedipine CC, six (6) 100 mg capsules of Gabapentin, eight (8) 100 mg tablets of hydralazine, two (2) 100 mg tablets of trazodone, two (2) 50 mg tablets of sertraline, two (2) 100 mg tablets of sertraline, six (6) 15 mg tablets of buspirone, two (2) 15 mg tablets of mirtazapine, four (4) 20 milliequivalent tablets of potassium chloride extended release, and two (2) 120 mg tablets of Isosorbide Mononitrate Extended Release. The packing slip also denoted thirty (30) 175 microgram tablets of levothyroxine (used to treat hypothyroidism) for another resident, Resident #2. The nurse's note dated 5/4/26 at 1:47 PM identified Resident #1 remained on the LOA when Resident #1 was scheduled to return on 5/3/26. The note indicated a family called the facility and Resident #1 would return after 3:00 PM today. The nurse's note dated 5/4/26 at 3:31 PM identified Resident #1 returned at 3:30 PM. The Resident Grievance Report dated 5/6/26 identified Resident #1's guardian reported that when Resident #1 went home on the weekend LOA he/she observed Resident #1 was given another resident's medication along with Resident #1's. Interview with the 7AM-3PM charge nurse, Licensed Practical Nurse (LPN) #1, on 6/1/26 at 12:11 PM identified the pharmacy, following review, would send the appropriate amount of medication, individually packaged, directly to the facility, and the nurse signing for the medications was to reconcile the order prior to distributing the medications to the resident. LPN #1 indicated she had received the sealed bag of Resident #1's medications from the 11PM-7AM charge nurse, LPN #2, at the start of her shift on 5/2/26 and was informed it was all set. LPN #1 explained she did not open the bag containing Resident #1's medications to review the medications to ensure they were Resident #1's medications, she did not review the medications with the resident and responsible party prior to Resident #1 leaving the facility that day, she just gave them to Resident #1's responsible party as she was in the middle of giving shift report. Interview with the Director of Nursing (DON) on 6/1/26 at 12:52 PM identified the standard of practice was for the charge nurse to review the resident's medications with the resident and/or family members prior to exiting the facility for a LOA. Interview with the 11PM-7AM charge nurse, LPN #2, on 6/1/26 at 4:30 (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PM identified she had received an overnight medication delivery from the pharmacy that had medication for Resident #1, intended for his/her LOA. LPN #2 identified there was a long list of medications on the packing ship which listed Resident #1's name, and upon opening the bag, had realized the medications were for Resident #1's leave of absence. LPN #2 indicated she pushed the medications back into the bag, stapled the bag shut, printed on the back of the packing list Resident #1's name, LOA, and taped it to the bag for the next shift nurse to distribute. LPN #2 identified she expected the 7AM-3PM charge nurse to review Resident #1's medications and directions for use with Resident #1 and the responsible party as Resident #1 would be leaving during LPN #1's shift. LPN #2 indicated she did not reconcile the medications as Resident #1's name was the only name listed on the packing list. Review of the Discharge/Leave of Absence (Out on Pass) Medications Policy directed the nurse shall be responsible for counting all medication(s) (including controlled substances) and entering all of the information on the Out on Pass/Discharge-Release of Medication form, was responsible for obtaining the signature of the resident/responsible party on the Out on Pass/Discharge-Release of Medication form, and was to sign the Out on Pass/Discharge-Release of Medication form after obtaining the resident/responsible party signature.