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	07/01/2026

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 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** Based on review of the clinical record, facility documentation/policies and interviews, for two (2) of four (4) sampled residents (Residents #3 and #4) reviewed for abuse, the facility failed to ensure a safe and abuseˆfree environment when Resident #4 physically assaulted Resident #3. The facility did not provide adequate supervision or timely intervention, resulting in Resident #3 being struck multiple times, sustaining actual physical harm including facial injury, oral laceration, head trauma, and a loose tooth, and requiring hospital evaluation. The findings include:1.Resident #3's diagnoses included bipolar disorder, cognitive communication deficit, and cirrhosis of the liver.The quarterly Minimum Data Set assessment dated [DATE] identified Resident #3 as moderately cognitively impaired (Brief Interview for Mental Status (BIMS) score of 10) and required touching assistance or supervision with daily living skills. Resident #3 was independent with transfers and bed mobility.The Resident Care Plan (RCP) dated 4/16/26 identified Resident #3 had a selfˆcare deficit. Interventions directed assisting with care as needed, promoting selfˆcare in all areas, implementing fallˆrisk interventions due to limited mobility including nonskid footwear, monitoring blood sugars, and educating family and friends regarding safety reminders especially during periods of high heat.The Social Services note dated 6/2/26 at 08:43 AM by SW #1 identified follow up with Resident #3 due to an incident in which Resident #3 was physically assaulted by Resident #4, resulting in injury. Resident #3 was provided support and evaluated by psychiatry. The care plan was updated. The nurse's note dated 6/2/26 at 3:46 PM by RN #1 identified Resident #3 suffered a facial injury after being struck multiple times in the head and face by Resident #4 in the dining area as he/she was preparing to play his/her guitar resulting in bleeding from the mouth and a loose rightˆsided tooth. Resident #3 was found lying on the floor and was alert, oriented, and able to recall the incident. He/she complained of a headache but denied dizziness. Vital signs were monitored, a cold compress was applied, and the Advanced Practice Registered Nurse (APRN) requested hospital transfer for evaluation. The physician and the resident's sister were notified.The nurse's note dated 6/3/26 at 8:00 AM by RN #1 identified Resident #3 returned from the hospital. Resident #3 was diagnosed with a closed head injury with internal mouth laceration. CT scans of the head, cervical spine, and maxillofacial bones showed no significant traumatic injury. A followˆup with the primary care physician was recommended, and no new orders were given. Resident #3 was alert and oriented, complaining of headache and mouth pain. Tylenol was administered, and neuro assessments initiated.The physician's note dated 6/8/26 at 1:57 PM identified Resident #3 reported nearˆcomplete resolution of jaw discomfort and no longer felt his teeth were loose. No other medical issues or concerns were identified at the time.2. Resident #4's diagnoses included dementia, schizoaffective disorder. generalized anxiety disorder, and vitamin D deficiency.The quarterly Minimum Data Set assessment dated [DATE] identified Resident #4 as severely cognitively impaired (Brief Interview for Mental Status (BIMS) score of 00) and required touching assistance with activities of daily living. Resident #4 was independent with bed mobility, transfers, and ambulation.The RCP dated 5/7/26 identified Resident #4 as having selfˆcare deficit related to dementia and taking psychotropic medications due to schizoaffective disorder. (continued on next page)

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

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

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interventions directed allowing the resident to perform as much self˜care as possible and assisting as needed, re˜approaching during episodes of care refusal, asking the resident's name before providing care, monitoring for complications related to psychotropic medications, AIMS testing, behavior monitoring, gradual dose reduction as indicated, monitoring for changes in mental status and medication changes, and arranging psychiatric visits as needed.The Social Services note dated 6/2/26 at 8:08 AM identified SW #1 followed up with Resident #4 after an incident in which Resident #4 was physically aggressive toward Resident #3 causing injury. Resident #4 was provided support, evaluated by psychiatry and placed on one-to-one observation. The resident was advised to reach out to staff to resolve personal issues or concerns.The nurse's note dated 6/2/26 at 5:31 PM by RN #1 identified Resident #4 was physically aggressive toward Resident #3, causing injury. The residents were separated. Resident #4 refused vital signs and requested to be left alone following the incident. Emergency Medical Services (EMS) responded, and Resident #4 was transferred to the hospital. The nurse's note by RN #1 dated 6/3/26 at 10:46 AM identified the hospital physician reported Resident #4 was admitted to the psychiatric hospital for further evaluation and treatment where he/she currently remained.Interview with LPN #1 on 7/1/26 at 10:45 AM identified she worked with Resident #4 for three (3) years and never witnessed Resident #4 physically aggressive towards another resident. She witnessed Resident #4 physically aggressive towards a staff member one (1) time within the last year. On 6/2/26 at approximately 2:45 PM LPN #1 was at the nurse's station charting and heard Resident #4 in the resident lounge behind the nurse station talking to him/herself. She then heard Resident #3 screaming for help and saying he/she was bleeding. Resident #3 was observed on the floor and Resident #4 was standing several feet away from Resident #3. Resident #3 stated, He/she (Resident #4) punched me. Resident #4 was very agitated and kept repeating, He/she is minding my business. The psychiatric APRN was present and directed staff to administer Haldol 10 mg by mouth one time to Resident #4. LPN #1 walked Resident #4 back to his/her room, initiated one-to-one observation and waited for the police to arrive. Resident #4 was known to talk to him/herself frequently in Russian and was redirectable when staff would engage in conversation.Interview with Resident #3 on 7/1/26 at 1:20 PM identified he/she recalled being struck by Resident #4. Resident #3 identified that he/she went into the lounge to play the guitar. As he/she was about to open the guitar case Resident #4 approached Resident #3 and began screaming at him/her about playing the guitar then Resident #4 began punching him/her in the face. Resident #3 further identified his/her tooth was initially loose but was no longer loose.Interview with the DON on 7/1/26 at 2:46 PM identified based on the facility Abuse Policy, on 6/2/26, the facility failed to keep Resident #3 free from abuse when another resident struck Resident #3.Review of the facility Abuse Policy identified Residents would not be subjected to abuse by anyone.