STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055078	A. Building B. Wing	08/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Parkway Hills Nursing & Rehabilitation	7760 Parkway Drive LA Mesa, CA 91942

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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 - Some	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46235 Based on observation, interview, and record review, the facility failed to provide a safe and homelike environment for residents residing in the facility when: 1. Hallway floors were taped and with missing floorings, 2. A handrail was observed loose and wobbly. This failure had the potential for residents to trip, fall and sustain injury. Findings: 1. During the initial tour of the facility on 8/20/24 at 8:26 A.M., the hallway floors were observed to have gray duct tape (tape used for general sealing, patching holes, and repairs) to secure the flooring. Multiple duct tapes extended from the flooring in the front nursing station to both hallways of the facility. One hallway had missing flooring in front of room [ROOM NUMBER] which created an uneven surface. a. Resident 30 was admitted to the facility on [DATE] with diagnoses including muscle weakness according to the facility's Admission Record. On 8/21/24 at 9:52 A.M. Resident 30 was observed walking into room [ROOM NUMBER] using a cane. During an interview on 8/22/24 at 7:53 A.M. with Resident 30, Resident 30 stated the tape on the floors was bothersome. Resident 30 stated there was no glue to keep the flooring stable. Resident 30 stated he walked with a cane and made sure he had shoes on to prevent injury. Resident 30 further stated he can get hurt while walking down the hallways. During a review of Resident 30's care plan date initiated on 9/18/23, the care plan indicated, At risk for accidents, FALLS r/t (related to) .unsteady gait . b. Resident 32 was admitted to the facility on [DATE] with diagnoses including history of falling and muscle weakness according to the facility's Admission Record. (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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview and observation on 8/23/24 at 8:25 A.M. with Resident 32, Resident 32 was observed walking in the halls without an assistive device (cane or walker). Resident 32 stated his room was in 21C, just past the area with missing flooring. Resident 32 stated the missing flooring Could be a problem. I get scared. An interview and joint observation was conducted on 8/22/24 at 8:25 A.M. with the maintenance director (MT). The MT observed the missing flooring in front of room [ROOM NUMBER] and the hallway flooring with duct tape. The MT stated the flooring was already taped up when he started in April 2024. An interview was conducted on 8/23/24 at 11:23 A.M., with the Director of Nurses (DON). The DON stated she was aware of the condition of the floors in the hallways and the flooring was a tripping hazard. 2. On 8/22/24 at 7:55 A.M., the handrail outside room [ROOM NUMBER] was observed to be wobbly and with a loose screw to secure the handrail. During an interview and joint observation on 8/22/24 at 8:14 A.M. with CNA 21, CNA 21 stated the handrail outside room [ROOM NUMBER] was loose. CNA 21 stated the handrail could be harmful for residents and staff. CNA 21 also observed the missing flooring outside of room [ROOM NUMBER] and stated the area with the missing flooring was dangerous for staff and residents because of the uneven surface. CNA 21 further stated usually there was a caution sign in the hallway, but none was observed today, 8/22/24. An interview and joint observation was conducted on 8/22/24 at 8:25 A.M. with the MT. The MT observed the handrail outside room [ROOM NUMBER] with a loose screw. The MT stated he did not have a routine schedule to check handrails and was just notified about the broken handrail. The MT stated he should have a schedule to check handrails to prevent injury. During a review of the facility's policy and procedure titled Homelike Environment dated February 2021, the policy indicated, .Residents are provided with a safe, clean, comfortable and homelike environment .

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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 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** 48263 Based on observations, interviews, and record review, the facility failed to accurately code the Minimum Data Set (MDS: a nursing assessment tool) for one of five residents (Resident 31) reviewed for vaccination status. As a result, the facility sent Resident 31's MDS to the federal database with inaccurate vaccination status. Cross Reference F883 Findings: 1. A review of Resident 31's Admission Record indicated Resident 31 was readmitted to the facility on [DATE] with diagnoses which included a history of congestive heart failure (is a long-term condition that occurs when the heart is not able pump enough blood to meet the body's needs. This can happen when the heart is too weak or stiff to pump properly, or if it can't fill up with enough blood. As a result, blood backs up in the heart, or becomes congested). A record review of Resident 31's MDS dated [DATE], indicated a Brief Interview for Mental Status (BIMS-developed by reviewing the resident's status during the prior seven-day period) score of 15 points out of 15 possible points which indicated Resident 31 was cognitively (pertaining to memory, judgement and reasoning ability) intact. On 8/23/24 at 9:48 A.M., a concurrent interview and record review was conducted with the Infection Prevention (IP) nurse, in the conference room. The IP stated that Resident 31 had a consent form dated 1/20/24 during vaccine season (October 1 through March 31 annually) 2023-2024 but did not receive an updated pneumonia (a respiratory infection caused by bacteria, virus or fungi that causes the lungs to be inflamed making it hard for oxygen to circulate in the blood stream that can cause discomfort and difficulty with breathing) vaccine according to the Center's for Disease Control (CDC) vaccine recommendations. The IP nurse stated it was important to offer and administer an updated pneumonia vaccine to prevent pneumonia and because Resident 31 had a history of pneumonia. The IP reviewed Resident 31's MDS on 5/25/24 Section O0300 Pneumococcal Vaccine (Is the resident's Pneumococcal vaccination up to date?) that was coded 1 for yes. The IP stated that the MDS was inaccurately coded because an updated pneumonia vaccine was not administered. On 8/23/24 at 10:00 A.M., a record review was conducted in Resident 37's electronic vaccination record. There was no documentation of an updated pneumonia vaccine administered. On 8/23/24 at 11:29 A.M., an interview was conducted with Resident 31, in Resident 31's room. Resident 31 stated he received the COVID-19 (coronavirus: A highly contagious respiratory disease caused by the SARS-CoV-2 virus) and Flu (influenza: contagious respiratory disease caused by different strains of viruses) vaccine but was not offered or given an updated pneumonia vaccine. Resident 31 stated I'd consent to it if they offered me an updated pneumonia vaccine. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/23/24 2:30 P.M., an interview with the Director of Nursing (DON) was conducted. The DON stated Resident 31's MDS should be corrected to reflect an accurate assessment since the pneumonia vaccine was not up to date to accurately reflect Resident 31's assessment status. The DON stated that her expectations were for the MDS should be coded per the Resident Assessment Instrument (RAI: MDS manual for coding) A review of Centers for Medicare and Medicaid Services (CMS, a federal agency) RAI Manual 3.0 October 2023, (Page O-17) Section O0300A: Pneumococcal Vaccine . Code 0, no: if the resident's pneumococcal vaccination status is not up to date or cannot be determined. Proceed to item O0300B, If Pneumococcal vaccine not received, state reason

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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** 46235 Based on observation, interview, and record review, the facility failed to update a resident centered care plan for one resident (Resident 6) with a continuous positive airway pressure (CPAP - a machine that delivers mild air pressure through the nose to keep breathing airways open while asleep) machine reviewed for care plans. This deficient practice had the potential for Resident 6 to not receive a resident centered and appropriate care and treatment. Findings: Resident 6 was admitted to the facility on [DATE] with diagnoses including obstructive sleep apnea (OSA- a problem in which breathing pauses during sleep due to blocked airways) according to the facility's Admission Record. During an observation on 8/21/24 at 8:56 A.M. Resident 6 was in bed with a red hat covering her eyes. Resident 6 did not respond when greeted. A CPAP machine was observed on top of a plastic container with 2 drawers on the right side of the bed. The mask for the CPAP machine was on top of Resident 6's bed. During an interview on 8/21/24 at 11:16 A.M. with licensed nurse (LN) 1, LN 1 stated Resident 6 applied the CPAP mask on at night and removed it in the morning. During a concurrent record review and interview on 8/22/24 at 9:22 A.M. with the Minimum Data Set Nurse (MDSN- a nurse who assessed and evaluated the quality of care being given to residents), the MDSN reviewed Resident 6's care plans dated 2/8/24. The MDSN stated the care plan for the CPAP did not include the settings and the cleaning of the CPAP's tubing and mask. The MDSN further stated if it was not documented, it was not done. During a review of the facility's policy and procedure (P&P) titled Care Plans, Comprehensive Person-Centered revised March 2022, the P&P indicated, . The care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment .The comprehensive, person-centered care plan .describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychological well-being .

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43518 Based on observation, interview, and record review, the facility failed to ensure 2 of 9 residents (Resident 43 and Resident 30) reviewed for activities of daily living (ADL-basic tasks of everyday life) received assistance with nail care. This deficient practice had the potential to affect the residents' dignity, cause infection from the debris under the fingernails and cause injury from having long, jagged fingernails. Findings: 1. Review of Resident 43's Admission record indicated Resident 43 was admitted on [DATE] with diagnoses which include Hemiplegia (Loss of strength in the arm, leg, and sometimes face on one side of the body) and Hemiparesis (one-sided muscle weakness). Review of Minimum Data Set (MDS-A standardized assessment tool used to evaluate the health status of residents in Medicare and Medicaid certified nursing homes) Section C-Cognitive Patterns dated June 20, 2024 indicated a Brief Interview for Mental Status (BIMs-a test that assesses a patient's orientation, learning, and memory) score of 13, which indicated intact cognition. Review of MDS section GG- Functional Abilities and Goals dated June 20, 2024, indicated that Resident 43 was assessed as .Functional Limitation in range of motion .A. Upper extremity. Resident 43 was classified as 1. Dependent-a helper completed all activities for resident. Resident 43's personal hygiene was classified as 02. Substantial/maximal assistance-Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort. Review of Resident 43's Care Plan dated 12/19/23 indicated .Impaired physical mobility as manifested by impaired gait, balance, decreased range of motion, requires assistance with ADL needs .Interventions .Keep, clean dry, well-groomed at all times . On 8/20/24 at 11:13 A.M., an observation and interview were conducted with Resident 43 in the resident's room. Resident 43 was observed with a splint on his left hand and forearm. Resident 43's right hand had long nails on all fingers. Resident 43's right thumb nail appeared thick, gray, and was covered in orange yellowish substance. Resident 43's right thumb nail curved down around exterior of his right thumb. Resident 43 stated that his thumb got caught in a motor, years ago, and he attached an acrylic (artificial) nail to protect it. Resident 43 stated nobody had cut it, because they were afraid. On 8/22/24 at 1:45 P.M., an observation and interview were conducted with Resident 43 in the courtyard of the facility. Resident 43's right fingernails were observed unchanged from 8/20/24, long with debris under nail. Resident 43 stated that he asked the Certified Nursing Assistant (CNA) to cut them, but she didn't. Resident 43 stated he thought the last time someone cut this right thumb nail was his primary doctor a few years ago. Resident 43 stated that podiatry cut his toenails, but no one had cut the nails on his right hand for a long time. Resident 43 stated that he is able to cut his own left-hand fingernails, but since his left hand is weak, he cannot cut his right-hand fingernails. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/22/24 at 1:50 P.M., an interview with CNA 11 was conducted. CNA 11 stated that the resident's fingernails should be cut at least once a week when the resident gets a shower. CNA 11 stated the importance of cutting a resident's fingernails was to prevent injury from scratching and to prevent infection from dirt and debris under the nails. On 8/22/24 at 2 P.M., an interview with CNA 12 was conducted. CNA 12 stated that she did not cut Resident 43's nails because she thought he might be sick and wanted to ask the Licensed Nurse (LN) before cutting his nails. CNA 12 stated the expectation is to cut the fingernails once a week when the resident showers. CNA 12 stated the importance of cutting the nails weekly is to prevent injury from scratching and infection from the jam under his nails. On 8/22/24 at 2:10 P.M., an observation of Resident 43's fingernails and interview with Licensed Nurse (LN) 1 was conducted. LN 1 stated that resident's fingernails should be cut at least once a week with their shower. LN 1 stated that the importance of trimming resident's fingernails is to prevent injury from scratching and infection prevention from dirt under resident's fingernails. On 8/22/24 at 2:30 P.M., a concurrent observation and interview of Resident 43's fingernails with the Director of Nursing (DON) were conducted. The DON stated the expectation is that the resident's fingernails should be trimmed weekly with their shower. The DON stated the importance of trimming resident's fingernails weekly is to prevent injury from sharp nails and infection from any residue under the nails. Review of facility policy and procedure titled Fingernails/Toenails, Care of, dated February 2018 indicated .1. Nail care to be done weekly with showers and as needed for care and cleaning .6. Stop and report to nurse supervisor if there is evidence of ingrown nails, infections, pain, or nails are too hard or too thick to cut with ease . 46235 2. Resident 30 was admitted to the facility on [DATE] with diagnoses including dementia (an impairment of brain function, such as memory loss and judgment) and muscle weakness according to the facility's Admission Record. During observation and interview on 8/20/24 at 9:44 A.M. with Resident 30, Resident 30's fingernails were observed to be long and jagged. Resident 30 stated he did not feel well and would like assistance to have his fingernails trimmed. During observation and interview on 8/21/24 at 9:52 A.M., Resident 30 was observed walking into his room with a cane. Resident 30 stated nobody had trimmed his fingernails. Resident 30's fingernails were observed to be long and jagged. During observation and interview on 8/22/24 at 7:53 A.M., Resident 30 stated nobody had assisted him with his fingernails. Resident 30's fingernails were observed to be long and jagged. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted and on 8/22/24 at 8:38 A.M. with certified nurse assistant (CNA) 11. CNA 11 stated the facility policy allowed CNAs to trim resident's fingernails if the resident did not have diabetes (a condition of having too much sugar circulating in the blood), and a physician trimmed the toenails for residents. CNA 11 stated shaving and nail care were provided during resident's shower days. CNA 11 further stated it was dangerous for residents to have long fingernails and bacteria can enter the fingernails. An interview was conducted on 8/22/24 at 10:30 A.M. with licensed nurse (LN) 1. LN 1 stated she expected CNAs to trim residents' fingernails when they were long if residents did not have diabetes. LN 1 stated it was important to trim fingernails when long because it can scratch the resident and cause a skin tear. During an interview on 8/23/24 at 8:32 A.M. with the Director of Staff Development (DSD), the DSD stated she expected residents to look clean with nail care provided on shower days and as needed. The DSD stated long fingernails can have bacteria and can cause a scratch. A review of Resident 30's shower sheet titled, Skin observation-Bath/Shower/Other, dated 8/20/24 was conducted. The shower sheet indicated, Nails Clipped, not needed .Need clipping, No . During an interview on 8/23/24 at 11:32 A.M. with the Director of Nurses (DON), the DON stated she expected nail care for residents to be done once a week on shower days and CNAs should file fingernails if a resident had diabetes. Review of facility policy and procedure entitled Fingernails/Toenails, Care of dated February 2018 indicated . 1. Nail care to be done weekly with showers and as needed for care and cleaning .6. Stop and report to nurse supervisor if there is evidence of ingrown nails, infections, pain, or nails are too hard or too thick to cut with ease . During a review of the facility's policy and procedure (P&P) titled Activities of Daily Living (ADLs), Supporting dated March 2018, the P&P indicated, .Appropriate care and services will be provided for residents .including appropriate support and assistance with .a. Hygiene (bathing, dressing, grooming, and oral care) .

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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** 46235 Based on observation, interview and record review, the facility failed to ensure a physician's order for the settings of a continuous positive airway pressure (CPAP-a machine that delivers mild air pressure through the nose to keep breathing airways open while asleep) was ordered for one (Resident 6) of three residents reviewed for respiratory care. This deficient practice had the potential for Resident 6 to receive inappropriate care and treatment which could lead to a decline in Resident 6's respiratory status. Findings: Resident 6 was admitted to the facility on [DATE] with diagnoses including obstructive sleep apnea (OSA- a problem in which breathing pauses during sleep due to blocked airways) according to the facility's Admission Record. During an observation on 8/21/24 at 8:56 A.M. Resident 6 was in bed with a red hat covering her eyes. Resident 6 did not respond when greeted. A CPAP machine was observed on top of a plastic container with 2 drawers on the right side of the bed. The mask for the CPAP machine was on top of Resident 6's bed. During an interview on 8/21/24 at 11:16 A.M. with licensed nurse (LN) 1, LN 1 stated Resident 6 applied the CPAP mask on at night and removed it in the morning. LN 1 stated the respiratory therapist (RT) was responsible for maintaining the CPAP machine. An interview and concurrent record review was conducted with the RT on 8/22/24 at 10:29 A.M. The RT stated Resident 6 brought her own CPAP machine from home. The RT reviewed the physician's orders for Resident 6 and stated there was no order for the CPAP settings. The RT stated the order indicated to apply CPAP during sleep hours at the preprogrammed settings and she did not know what the preprogrammed setting was. The RT stated there should be an order for the settings to check for accuracy and prevent Resident 6 from having shortness of breath. During a review of Resident 6's care plan date initiated on 2/8/24, the care plan indicated, Ineffective airway/SOB (shortness of breath) secondary to Medical Diagnosis . During an interview on 8/22/24 at 3:45 P.M. with Resident 6, Resident 6 stated staff should know the CPAP settings because they touch the buttons, and the settings could be altered. During an interview on 8/23/24 at 11:23 A.M. with the Director of Nurses (DON), the DON stated CPAP settings should be in the physician's order for staff to be aware of what to provide the resident. During a review of the facility's policy and procedure (P&P) titled, CPAP/BIPAP Support, dated March 2015, the P&P indicated, .Document the following in the resident's medical record .3. Mode and settings for the CPAP . (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The P&P did not provide guidance for staff regarding obtaining a physician's order for the CPAP machine prior to administration to the resident.

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. 43518 Based on interview and record review the facility failed to staff a Registered Nurse (RN) for at least 8 hours a day for 18 days from January 1, 2024 through March 31 of 2024. This failure had the potential for residents and staff to receive inadequate supervision and for residents to not receive an appropriate quality of care. Findings: Review of PBJ Staffing Data Report, CASPER Report 1705 (a report that can helped Skilled Nursing Facilities identify areas for improvement in care and operations) for January 1st through March 31, 2024 indicated ,No RN (Registered Nurse) hours was triggered for 19 days. On 8/23/24 at 9:15 A.M., a concurrent interview with the Staffing Coordinator (SC) and record review of staffing log for January 1st through March 31, 2024 was conducted. SC stated her records indicated the following days did not have an RN scheduled for at 8 least hours: January 1, 6, 7, 8, 20, 28 February 2, 3, 9 10, 11, 24, 25 March 2, 3, 9,10,17 SC stated that staffing numbers for Licensed Nurses (LN) and Certified Nursing Assistants (CNAs) were within limit those days, but they were unable to retain the services of an RN. SC stated facility had no waivers for staffing. SC stated that when they do not have a RN on schedule they have tried to accommodate with more LN's. SC stated they have tried in past to use registry for RNs, but registry can be undependable. SC stated the expectation is the facility should have RN at least 8 hours a day. SC stated the importance of having an RN at least 8 hours a day is to give Intravenous medication (IV-within the vein) and to oversee patient care and safety. On 8/23/24 at 10 A.M., an interview with the Director of Nursing (DON) was conducted. The DON stated that the facility should have an RN at least 8 hours a day, 7 days a week. The DON stated the importance of having an RN for at least 8 hours a day was for the RN to manage other staff, oversee resident care, insert IV's and give IV medication to residents. Review of the undated facility policy titled Staffing indicated, .Facility provides sufficient number of staff with the skills and competency necessary to provide care and services for all residents in accordance with resident care plans and facility assessment .4. Direct care staffing information per day (including agency and contract staff) is submitted to the CMS payroll-based journal system on the schedule specified by Centers for Medicare and Medicaid Services (CMS- government agency) but no less than once a quarter .

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Parkway Hills Nursing & Rehabilitation	7760 Parkway Drive LA Mesa, CA 91942

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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48263 Based on observations, interviews, and record review, the facility failed to prevent medication errors of less than 5% for three of eight sampled residents (Resident 37, Resident 31, and Resident 33) during medication pass observation with three licensed nurses (LN 1, LN 2 and LN 3) when: 1. LN 1 administered medications to Resident 37's gastronomy tube (G-tube: a surgical opening on the abdomen for nutritional and/or medication administration) omitting one medication to be administered and the full dose of medications administered (eight medication errors) . 2. LN 2 did not administer Resident 31's morning medications (9:00 A.M.) as scheduled for more than three hours (nine medication errors). 3. LN 3 did not administer Resident 33's Januvia (oral medication that lowers blood sugar) as scheduled due to medication not available in medication cart (one medication error). As a result, there were 18 medication errors and 36 total opportunities during a medication pass observation. The facility's medication error rate was 50%. Cross Reference F760 Findings: 1. A review of Resident 37's admission record indicated Resident 37 was readmitted to the facility on [DATE] with diagnoses which included a history of epilepsy (also known as seizures - uncontrolled jerking, blank stares, loss of consciousness)who required nutritional and medication administration through a G-tube. A record review of Resident 37's MDS (Minimum data set: nursing facility assessment tool) dated 7/29/24 indicated that Resident 37 was unable to participate with a cognitive (the mental processes that take place in the brain, including thinking, attention, language, learning, memory, and perception) brief interview for mental status and indicated that his cognitive skills for daily decision making was severely impaired (never/rarely made decisions). On 8/21/24 at 8:45 A.M., an observation, interview, and medication reconciliation (record review for safety prior to administration of medications) was conducted with LN 1, in Resident 37's room. LN 1 administered the following medications to Resident 37 via G-tube: (continued on next page)

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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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Benztropine is a medication for extrapyramidal symptoms (EPS- side effects of long-term use of psychotropic [medications that affects how the brain works and causes changes in mood, awareness, thoughts, feelings, or behavior medications] that exhibit a drug induced movement disorder). LN 1 crushed the medication in a plastic pill bag than transferred the contents into a clear unlabeled 30 ml (milliliters) medication cup and diluted (adding water to help administer medication through a G-tube) with 10 ml of water. Prior to administration LN 1 was unsure which medication she was administrating to Resident 37 because of similar white diluted unlabeled medication cups she had taken to Resident 37's room then mixed all the medication cups with the same G-tube syringe to the other remaining medications to be administered. After administrating the medication, LN 1 flushed Resident 37's G-tube site with 10ml of water for the next medication to be administered. The medication cup contained white remnants (undissolved crushed medication particles not administered) remaining in the medication cup. LN 1 stated there were still remnants in the medication cup. - Calcium is a supplement for nutrition. LN 1 crushed the medication in a plastic pill bag than transferred the contents into a clear unlabeled 30 ml medication cup and diluted with 10 ml of water. After administrating the medication, LN 1 flushed Resident 37's G-tube site with 10mL's of water for the next medication to be administered. The medication cup contained white remnants remaining in the medication cup. LN 1 stated there were still remnants still in the medication cup. - Vitamin D (a supplement for nutrition). LN 1 crushed the medication in a plastic pill bag than transferred the contents into a clear unlabeled 30 ml medication cup and diluted with 10 ml of water. After administrating the medication, LN 1 flushed Resident 37's G-tube site with 10ml of water for the next medication to be administered. The medication cup contained light orange remnants remaining in the medication cup. LN 1 stated there were still remnants in the medication cup. - Clonazepam is a medication used to treat anxiety (uneasy feeling), stop seizures or relax tense muscles. LN 1 crushed the medication in a plastic pill bag than transferred the contents into a clear unlabeled 30 ml medication cup and diluted with 10 ml of water. After administrating the medication, LN 1 flushed Resident 37's G-tube site with 10mL's of water for the next medication to be administered. The medication cup contained white with a light orange eraser tip sized remnants remaining in the medication cup. - MVI (multivitamin) is a supplement for nutrition. LN 1 crushed the medication in a plastic pill bag than transferred the contents into a clear unlabeled 30 ml medication cup and with 10 ml of water then re-diluted the medication cup with an additional 20 ml of water and re-administered the medication. After administrating the medication, LN 1 continued to flush Resident 37's G-tube site with an additional 10 ml of water for the next medication to be administered. The medication cup contained a golden brown thickened undissolved remnant remaining in the medication cup. - Levetiracetam is a medication for epilepsy management. LN 1 missed medication administration of medication until it was pointed out that medication was not given. LN 1 stated she had forgotten to administer medication because it had clear liquid that she thought had already been administered. LN 1 stated it was important Resident 37 received this medication to prevent seizures. On 8/21/24 at 9:00 A.M., an observation, interview and medication reconciliation record review was conducted with LN 1, in Resident 37's room. LN 1 administered the following medications to Resident 37 via G-tube: (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Irbesartan is a medication to manage high blood pressure (BP) and prevent heart complications. Prior to medication administration LN 1 took Resident 37's BP on Resident 37's left wrist with the result of 110/78. LN 1 crushed the medication in a plastic pill bag than transferred the contents into a clear unlabeled 30 ml medication cup and diluted with 10 ml of water. After administrating the medication, LN 1 continued to flush Resident 37's G-tube site with an additional 10 mL's of water for the next medication to be administered. The medication cup contained white remnants remaining in the medication cup. LN 1 stated there were still remnants still in the medication cup. On 8/21/24 at 9:20 A.M., an observation, interview and medication reconciliation record review was conducted with LN 1, in Resident 37's room. LN 1 administered the following medications to Resident 37 via G-tube: - Divalproex a medication for mood stability associated with depression (a constant feeling of sadness and loss of interest). LN 1 opened the capsule (is a small tube that contains powdered or liquid medication) and removed the medication granules and transferred the granules in a clear unlabeled medication cup then added 10 ml's of water then took the medication to Resident 37 to administer the medication. LN 1 used a small plastic spoon to mix the contents of the granules then transferred to the 60 ml syringe for administration. LN 1 stated that the granules in the syringe was getting clogged at the tip and that she was having problems getting the granules down in Resident 37's feeding tube so she removed the syringe and diluted the syringe with an additional 40 ml's of water then attempted to administer again in Resident 37's G-tube. LN 1 stated that there was still resistance to Resident 37's tube and removed the syringe with the medication granules still intact. LN 1 stated she should have used warm water to try and dissolve the granules prior to administration. LN 1 stated the medication cup and the syringe cup still had white undissolved granules along with the 60 ml syringe. On 8/21/24 at 10:00 A.M., an interview was conducted with LN 1. LN 1 stated the medications she administered to Resident 37's G-tube all still had remnants in them. LN 1 stated because the medications were not fully dissolved prior to administering all of Resident 37's medications, Resident 37 did not get the full dosage of his medications. LN 1 stated it was important that Resident 37 get the full dosage of all his medications to manage Resident 37's health complications to prevent seizures, hypertension (high blood pressure), stabilize his anxiety/mood and for nutritional support because Resident 37 relied on the G-tube for medication and nutritional management. On 8/22/24 at 2:04 P.M., an interview was conducted with the Director of Nursing (DON). The DON stated that her expectations for medication administration for all residents in the facility is that the medication nurses give medications according to their medication administration policy (right resident, right medication, right dosage, right time, and right route/method). The DON stated it was important to administer medications according to the five rights per policy to prevent complications for example a resident with hypertension to have their BP medications given per Physician's order to manage BP and prevent a hypertensive crisis, stroke, dizziness, anything cardiac related. For depression/psychotropic medications to have the intended therapeutic effects and levels, and seizure medications to prevent seizures. The DON stated prior to administering medications to Resident 37's G-tube, medications should be fully dissolved without remnants to get the complete dosage for the medication's intended therapeutic effects and safety. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the facility's policy and procedure titled ADMINISTRATING MEDICATIONS THROUGH AN ENTERAL TUBE undated, indicated, .General Guidelines . 1. Request liquid forms of medications from the pharmacy, if possible. 8. This procedure is contraindicated if the tube is obstructed .9. Dilute Medication . 2. A review of Resident 31's Admission Record indicated Resident 31 was readmitted to the facility on [DATE] with diagnoses which included a history of congestive heart failure (is a long-term condition that occurs when the heart is not able to pump enough blood to meet the body's needs. This can happen when the heart is too weak or stiff to pump properly, or if it can't fill up with enough blood. As a result, blood backs up in the heart, or becomes congested). A record review of Resident 31's Minimum Data Set (MDS- a nursing assessment tool that is used to develop a plan of care) dated 5/21/24, indicated a Brief Interview for Mental Status (BIMS- developed by reviewing the resident's status during the prior seven-day period) score of 15 points out of 15 possible points which indicated Resident 31 was cognitively (pertaining to memory, judgement and reasoning ability) intact. On 8/21/24 at 9:47 A.M., an observation was conducted in Resident 31's room. Resident 31 was asleep wearing a hospital gown laying in his bariatric (an oversized bed) bed. On 8/21/24 at 12:32 P.M., an observation, interview, and medication reconciliation (record review for safety prior to administration of medications) was conducted with LN 2, outside of Resident 31's room. LN 2 stated that she missed all of Resident 31's morning medications because Resident 31 was with the rehabilitation (rehab) therapy team. LN 2 stated the following medications were not administered at the scheduled 9 A.M., medication rounds which included: - Metformin an oral medication for diabetes (when the body is unable to control blood sugar in the blood stream leading to circulatory problems that can affect the heart, nerves, kidneys, eyes and cause multi-system complications) management. - Diltiazem a medication to prevent high blood pressure (BP). - Metoprolol Tartrate a medication that helps control BP. - Duloxetine a medication that treats depression (a constant feeling of sadness and loss of interest). - Senna a medication that helps prevent constipation. - Theragram multivitamin a supplement that supports nutrition. - Folic Acid (Vitamin B9) a supplement for nutritional health that can help the body make red blood cells. - Pregabalin medication to help with pain associated to neuropathy (nerve pain). - Magnesium Oxide is a supplement that can help with digestive problems heart burn (burning sensation in the chest associated with gas reflux). (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 8/21/24 at 12:41 P.M., an observation and interview was conducted with Resident 31 and LN 2, in Resident 31's room. Resident 31 stated he did not go to rehab in the morning and stated I get rehab at 1 P. M. and complained of a chronic 8 out of 10 shoulder pain but denied a headache. LN 2 stated I must have missed him in the morning then showed Resident 31's electronic medication administration record (MAR) that highlighted resident with the color red. Per LN 2 that Resident 31's MAR showed red to indicate medications were late. LN 2 stated all of Resident 31's 9 A.M., medications were three hours late and was not given on time. LN 2 stated it was important that Resident 31 get all his medications in a timely manner and that three hours was not an acceptable time frame. LN 2 stated Resident 31 was on hypertensive medications with a BP of 177/100 heart rate (HR) 89 and stated Resident 31 had two medications (Diltiazem and Metoprolol) to help control his BP and stated complications could include a hypertensive crisis (a rapid spike in BP that can result in a stroke). LN 2 stated Resident 31 was also on medications for diabetes (Metformin) and stated complications could include hyperglycemia (high blood sugar if left untreated can lead to a decreased level of consciousness). LN 2 stated Resident 31 was also on medication for depression (Duloxetine) and it was important that resident 31 to receive medication to continue the therapeutic effects to manage depressive symptoms. Lastly, LN 2 stated all of Resident 31's ordered medications should have been given timely to prevent complications with nutrition and health. On 8/22/24 at 2:08 P.M., a concurrent interview and record review was conducted with the Director of Nursing (DON) on Resident 31's clinical chart. Resident 31's progress note indicated that on 8/21/24 of a BP of 177/100 with a HR of 89 was observed on 8/21/24 during a medication pass observation with LN 1 at 12:41 P.M. The DON stated Resident 31 should have gotten his medications on time and that administering medications three hours late was not acceptable. The DON stated complications from Resident 31 not taking his BP medications on time to include uncontrolled blood pressure and a hypertensive crisis along with diabetic medications were important for the intent of keeping blood sugars stable. The DON stated it was important that meds are administered timely for the medications to continue its intended level of efficacy (effectiveness), safety, and therapeutic effects for health management for any resident's health diagnosis. A review of the facility's policy and procedure titled ADMINISTERING MEDICATIONS undated, indicated, . General Guidelines .7. Medications are administered within (1) hour of their prescribed time . 3. A review of Resident 33's Admission Record indicated Resident 33 was admitted to the facility on [DATE] with diagnoses which included a history of type two diabetes mellitus (when the body is unable to control blood sugar in the blood stream leading to circulatory problems that can affect the heart, nerves, kidneys, eyes and cause multi-system complications). A record review of Resident 33's Minimum Data Set (MDS- a nursing assessment tool that is used to develop a plan of care) dated 6/18/24, indicated a Brief Interview for Mental Status (BIMS- developed by reviewing the resident's status during the prior seven day period) score of 15 points out of 15 possible points which indicated Resident 31 was cognitively (pertaining to memory, judgement and reasoning ability) intact. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 8/22/24 at 8:21 A.M., an observation, interview, and medication reconciliation (record review for safety prior to administration of medications) was conducted with LN 3, in front of Resident 33's room. LN 3 stated Resident 33's Januvia (oral medication to control blood sugar) was not in the medication cart during the reconciliation of medications. LN 3 stated that he would not be able to administer Resident 33's Januvia because it was unavailable. LN 3 stated he was unaware if the medication had been ordered and needed to notify pharmacy to get the medication delivered. LN 3 stated it was important for Resident 33 to receive her Januvia medication for diabetes management and complications could include hyperglycemia (high blood sugar if left untreated can lead to a decreased level of consciousness). On 8/22/24 at 2:04 P.M., an interview was conducted with the Director of Nursing (DON). The DON stated that her expectations for medication administration for all residents in the facility is that the medication nurses give medications according to their medication administration policy (right resident, right medication, right dosage, right time, and right route/method). The DON stated it was important to administer medications according to the five rights per policy to prevent complications and for residents safety. The DON stated Resident 33's diabetic medication (Januvia) should be administered to continue the efficacy of the medication and it's intended use to control hyperglycemia and prevent further complications associated with diabetes. A review of the facility's policy and procedure titled ADMINISTERING MEDICATIONS undated, indicated, . General Guidelines .7. Medications are administered within (1) hour of their prescribed time .

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48263 Based on observation, interview, and record review, the facility failed to ensure three of eight sampled residents (Resident 37, Resident 31, and Resident 33) were free from significant medication errors when: 1. LN 1 administered medications to Resident 37's gastronomy tube (G-tube: a surgical opening on the abdomen for nutritional and/or medication administration) omitting one medication to be administered and the full dose of medications administered. 2. LN 2 did not administer Resident 31's morning medications (9:00 A.M.) as scheduled for more than 3 hours. 3. LN 3 did not administer Resident 33's Januvia (oral medication that lowers blood sugar) as scheduled due to medication not available in medication cart. As a result, Resident 37, Resident 31 and Resident 33 had the potential for serious health complications to cause discomfort and/or jeopardizes his or her health and safety. Cross Reference 759 Findings: 1. A review of Resident 37's admission record indicated Resident 37 was readmitted to the facility on [DATE] with diagnoses which included a history of epilepsy (also known as seizures - uncontrolled jerking, blank stares, loss of consciousness) who required nutritional and medication administration through a G-tube(gastronomy tube: a surgical opening on the abdomen for nutritional and/or medication administration). A record review of Resident 37's MDS (Minimum data set: nursing facility assessment tool) dated 7/29/24 indicated that Resident 37 was unable to participate with a cognitive (the mental processes that take place in the brain, including thinking, attention, language, learning, memory, and perception) brief interview for mental status and indicated that his cognitive skills for daily decision making was severely impaired (never/rarely made decisions). On 8/21/24 at 8:45 A.M., an observation, interview, and medication reconciliation (record review for safety prior to administration of medications) was conducted with LN 1, in Resident 37's room. LN 1 administered the following significant medications to Resident 37 via G-tube: (continued on next page)

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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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Benztropine is a medication for extrapyramidal symptoms (EPS-side effects of long-term use of psychotropic [medications that affects how the brain works and causes changes in mood, awareness, thoughts, feelings, or behavior medications] that exhibit a drug induced movement disorder). LN 1 crushed the medication in a plastic pill bag than transferred the contents into a clear unlabeled 30 ml (milliliters) medication cup and diluted (adding water to help administer medication through a G-tube) with 10 ml of water. Prior to administration LN 1 was unsure which medication she was administrating to Resident 37 because of similar white diluted unlabeled medication cups she had taken to Resident 37's room then mixed all the medication cups with the same G-tube syringe to the other remaining medications to be administered. After administrating the medication, LN 1 flushed Resident 37's G-tube site with 10 ml of water for the next medication to be administered. The medication cup contained white remnants (undissolved crushed medication particles not administered) remaining in the medication cup. LN 1 stated there were still remnants still in the medication cup. - Clonazepam is a medication used to treat anxiety, stop seizures or relax tense muscles. LN 1 crushed the medication in a plastic pill bag than transferred the contents into a clear unlabeled 30 ml medication cup and diluted with 10 ml of water. After administrating the medication, LN 1 flushed Resident 37's G-tube site with 10mL's of water for the next medication to be administered. The medication cup contained white with a light orange eraser tip sized remnants remaining in the medication cup. - Levetiracetam is a medication for epilepsy management. LN 1 missed medication administration of medication until it was pointed out that medication was not given. LN 1 stated she had forgotten to administer medication because it had clear liquid that she thought that the medication had already been administered. LN 1 stated it was important Resident 37 received this medication to prevent seizures. On 8/21/24 at 9 A.M., an observation, interview and medication reconciliation record review was conducted with LN 1, in Resident 37's room. LN 1 administered the following significant medications to Resident 37 via G-tube: - Irbesartan is a medication to manage high blood pressure (BP) and prevent heart complications. Prior to medication administration LN 1 took Resident 37's BP on Resident 37's left wrist with the result of 110/78. LN 1 crushed the medication in a plastic pill bag than transferred the contents into a clear unlabeled 30 ml medication cup and diluted with 10 ml of water. After administrating the medication, LN 1 continued to flush Resident 37's G-tube site with an additional 10 mL's of water for the next medication to be administered. The medication cup contained white remnants remaining in the medication cup. LN 1 stated there were still remnants in the medication cup. On 8/21/24 at 9:20 A.M., an observation, interview and medication reconciliation record review was conducted with LN 1, in Resident 37's room. LN 1 administered the following significant medications to Resident 37 via G-tube: (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Divalproex a medication for mood stability associated with depression (a constant feeling of sadness and loss of interest). LN 1 opened the capsule (is a small tube that contains powdered or liquid medication) and removed the medication granules and transferred the granules in a clear unlabeled medication cup then added 10 ml's of water then took the medication to Resident 37 to administer the medication. LN 1 used a small plastic spoon to mix the contents of the granules then transferred to the 60 ml syringe for administration. LN 1 stated that the granules in the syringe was getting clogged at the tip and that she was having problems getting the granules down in Resident 37's feeding tube so she removed the syringe and diluted the syringe with an additional 40 ml's of water then attempted to administer again in Resident 37's G-tube. LN 1 stated that there was still resistance to Resident 37's tube and removed the syringe with the medication granules still intact. LN 1 stated she should have used warm water to try and dissolve the granules prior to administration. LN 1 stated the medication cup and the syringe cup still had white undissolved granules along with the 60 ml syringe. On 8/21/24 at 10 A.M., an interview was conducted with LN 1. LN 1 stated the medications she administered to Resident 37's G-tube all still had remnants in them. LN 1 stated because the medications were not fully dissolved prior to administering all of Resident 37's medications, Resident 37 did not get the full dosage of his medications. LN 1 stated it was important that Resident 37 get the full dosage of all his medications to manage Resident 37's health complications to prevent seizures, hypertension (high BP), and stabilize his anxiety (feeling uneasy)/mood and for nutritional support because Resident 37 relied on the G-tube for medication and nutritional management. On 8/22/24 at 2:04 P.M., an interview was conducted with the Director of Nursing (DON). The DON stated that her expectations for medication administration for all residents in the facility is that the medication nurses give medications according to their medication administration policy (right resident, right medication, right dosage, right time, and right route/method). The DON stated it was important to administer medications according to the five rights per policy to prevent complications for example a resident with hypertension to have their BP medications given per Physician's order to manage BP and prevent a hypertensive crisis (extremely high blood pressure), stroke (brain attack), dizziness, anything cardiac related. For depression/psychotropic medications to have the intended therapeutic effects and levels, and seizure medications to prevent seizures. The DON stated prior to administering medications to Resident 37's G-tube, medications should be fully dissolved without remnants to get the complete dosage for the medication's intended therapeutic effects and safety. A review of the facility's policy and procedure titled ADMINISTRATING MEDICATIONS THROUGH AN ENTERAL TUBE undated, indicated, .General Guidelines . 1. Request liquid forms of medications from the pharmacy, if possible. 8. This procedure is contraindicated if the tube is obstructed .9. Dilute Medication . 2. A review of Resident 31's Admission Record indicated Resident 31 was readmitted to the facility on [DATE] with diagnoses which included a history of congestive heart failure (is a long-term condition that occurs when the heart is not able to pump enough blood to meet the body's needs. This can happen when the heart is too weak or stiff to pump properly, or if it can't fill up with enough blood. As a result, blood backs up in the heart, or becomes congested). (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A record review of Resident 31's Minimum Data Set (MDS- a nursing assessment tool) dated 5/21/24, indicated a Brief Interview for Mental Status (BIMS- developed by reviewing the resident's status during the prior seven-day period) score of 15 points out of 15 possible points which indicated Resident 31 was cognitively (pertaining to memory, judgement and reasoning ability) intact. On 8/21/24 at 9:47 A.M., an observation was conducted in Resident 31's room. Resident 31 was asleep wearing a hospital gown laying in his bariatric (oversized bed) bed. On 8/21/24 at 12:32 P.M., an observation, interview, and medication reconciliation (record review for safety prior to administration of medications) was conducted with LN 2, outside of Resident 31's room. LN 2 stated that she missed all of Resident 31's morning medications because Resident 31 was with the rehabilitation (rehab) therapy team. LN 2 did not administer the following significant medications as ordered during her morning (9 A.M.) medication rounds which included: - Metformin an oral medication for diabetes (when the body is unable to control blood sugar in the blood stream leading to circulatory problems that can affect the heart, nerves, kidneys, eyes and cause multi-system complications) management. - Diltiazem a medication to prevent high blood pressure (BP). - Metoprolol Tartrate a medication that helps control BP. - Duloxetine a medication that treats depression (a constant feeling of sadness and loss of interest). - Senna a medication that helps prevent constipation. - Pregabalin medication to help with pain associated to neuropathy (nerve pain). On 8/21/24 at 12:41 PM an observation and interview was conducted with Resident 31 and LN 2, in Resident 31's room. Resident 31 stated he did not go to rehab in the morning and stated that I get rehab at 1 P.M. and complained of a chronic 8/10 shoulder pain but denied a headache. LN 2 stated I must have missed him in the morning then showed Resident 31's electronic medication administration record (MAR) that highlighted resident with the color red. Per LN 2 that Resident 31's MAR showed red to indicate medications were late. LN 2 stated all of Resident 31'2 9 A.M., medications were three hours late and was not given on time. LN 2 stated it was important that Resident 31 get all his medications in a timely manner and that three hours was not an acceptable time frame. LN 2 stated Resident 31 was on hypertensive medications with a BP of 177/100 heart rate (HR) 89 and stated Resident 31 had two medications (Diltiazem and Metoprolol) to help control his BP and stated complications could include a hypertensive crisis (a rapid spike in BP that can result in a stroke). LN 2 stated Resident 31 was also on medications for diabetes (Metformin) and stated complications could include hyperglycemia (high blood sugar if left untreated can lead to a decreased level of consciousness). LN 2 stated Resident 31 was also on medication for depression (Duloxetine) and it was important that resident 31 to receive medication to continue the therapeutic effects to manage depressive symptoms. LN 2 stated all of Resident 31's ordered medications should have been given timely to prevent complications with nutrition and health. (continued on next page)

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Parkway Hills Nursing & Rehabilitation	7760 Parkway Drive LA Mesa, CA 91942

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 8/22/24 at 2:08 P.M., a concurrent interview and record review was conducted with the Director of Nursing (DON) on Resident 31's clinical chart. Resident 31's progress note indicated that on 8/21/24 of a BP of 177/100 with a HR of 89 was observed on 8/21/24 during a medication pass observation with LN 1 at 12:41 P.M. The DON stated Resident 31 should have gotten his medications on time and that administering medications three hours late was not acceptable. The DON stated complications from Resident 31 not taking his BP medications on time to include uncontrolled blood pressure and a hypertensive crisis along with diabetic medications were important for the intent of keeping blood sugars stable. The DON stated it was important that medications are administered timely for the medications to continue its intended level of efficacy (effectiveness), safety, and therapeutic effects for health management for any resident's health diagnosis. A review of the facility's policy and procedure titled ADMINISTERING MEDICATIONS undated, indicated, . General Guidelines .7. Medications are administered within (1) hour of their prescribed time . 3. A review of Resident 33's Admission Record indicated Resident 33 was admitted to the facility on [DATE] with diagnoses which included a history of type two diabetes mellitus (abnormal blood sugar in the body). A record review of Resident 33's Minimum Data Set (MDS- a nursing assessment tool that is used to develop a plan of care) dated 6/18/24, indicated a Brief Interview for Mental Status (BIMS- developed by reviewing the resident's status during the prior seven day period) score of 15 points out of 15 possible points which indicated Resident 31 was cognitively (pertaining to memory, judgement and reasoning ability) intact. On 8/22/24 at 8:21 A.M., an observation, interview, and medication reconciliation (record review for safety prior to administration of medications) was conducted with LN 3, in front of Resident 33's room. LN 3 stated Resident 33's Januvia (oral medication to control blood sugar) was not in the medication cart during the reconciliation of medications. LN 3 stated that he would not be able to administer Resident 33's Januvia because it was unavailable. LN 3 stated he was unaware if the medication had been ordered and needed to notify pharmacy to get the medication delivered. LN 3 stated it was important for Resident 33 to receive her Januvia medication for diabetes management and complications could include hyperglycemia (high blood sugar). On 8/22/24 at 2:04 P.M., an interview was conducted with the DON. The DON stated that her expectations for medication administration for all residents in the facility is that the medication nurses give medications according to their medication administration policy (right resident, right medication, right dosage, right time, and right route/method). The DON stated it was important to administer medications according to the five rights per policy to prevent complications and for residents safety. The DON stated Resident 33's diabetic medication (Januvia) should be administered to continue the efficacy of the medication and it's intended use to control hyperglycemia and prevent further complications associated with diabetes. A review of the facility's policy and procedure titled ADMINISTERING MEDICATIONS undated, indicated, . General Guidelines .7. Medications are administered within (1) hour of their prescribed time .

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48263 Based on observation, interview, and record review, the facility failed to ensure one resident medications (Resident 1) were secured and locked during a medication storage inspection. This failure had the potential for medication misuse, divergence (another person taking medications or medications used wrongfully), and unauthorized person to have access to the medications. Findings: A review of Resident 1's Admission Record indicated Resident 1 was readmitted to the facility on [DATE] with diagnoses which included a history of epilepsy (also known as seizures - uncontrolled jerking, blank stares, loss of consciousness). A record review of Resident 1's Minimum Data Set (MDS- a nursing assessment tool that is used to develop a plan of care) dated 7/3/24, indicated a Brief Interview for Mental Status (BIMS- developed by reviewing the resident's status during the prior seven day period) score of 11 out of 15 possible points which indicated Resident 1 had moderate cognitive (pertaining to memory, judgement and reasoning ability) deficits. On 8/21/24 at 10:13 A.M., an observation and interview was conducted with Resident 1 and CNA 1, in Resident 1's room. Resident 1's bedside table had an unlabeled and unattended clear medication cup that contained six medications (two white oblong shaped pills, one red circle pill, one yellow circle pill, one golden gel pill, and one oblong shaped yellow pill) placed at the top left of Resident 1's bedside table. Resident 1 stated that LN 2 had left the medication cup on the table for Resident 1 to take later. CNA 1 stated she was taking care of Resident 1's room mate and witnessed the medication cup with medications on Resident 1's table. CNA 1 stated that LN 2 was just in Resident 1's room passing medications. CNA 1 stated that medications should not be kept at the bedside and unattended for the safety of the resident. On 8/21/24 at 10:14 A.M., an interview was conducted with LN 2, in Resident 1's room. LN 2 stated I should not have left the medications at resident's (Resident 1) bedside. LN 2 stated that Resident 1 did not want to take her medications when she was in her (Resident 1) room as to the reason why she left the medications unattended in order for LN 2 not to be late administering the rest of the medications to other residents. LN 2 stated Resident 1's medications included Clonazepam for stabilizing Resident 1's anxiety, a medication for fenofibrate for high triglyceride (fat in the bloodstream), fish oil capsule as a supplement, a multi-vitamin supplement, a vitamin D supplement pill, and Depakote (mood stabilizer). On 8/21/24 at 10:18 A.M., an interview was conducted with LN 4, in Resident 1's room. LN 4 stated no medications should be left at the bedside due to potential to not be given [sic] or medications diverged to someone else to take meds and cause med errors. Lastly, LN 4 stated medications left unattended could also cause an emergent choke hazard for Resident 1. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/22/24 at 2:21 PM an interview was conducted with the DON. The DON stated her expectations were for LN's to not leave medications unattended for safety and to avoid medication divergence that can potentially happen if left unattended along with side effects not addressed appropriately. A review of facility's policy and procedure titled STORAGE OF MEDICATIONS undated, indicated, .The facility stores all drugs and biologicals in a safe, secure,, and orderly manner .

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. 43518 Based on observation, interview, and record review the facility failed to ensure kitchen staff (dishwashers) had the competency to use, operate, document and check the water temperatures of two low temperature dishwashers. This failure increased the risk of food borne illness being transmitted via dirty dishware. On 8/21/24 at 8 A.M., a concurrent observation of low temperature dishwasher, interview with Dishwasher (DW) 11, and record review of Dish Machine Temperature Log was conducted. DW 11 stated that the process for washing the dishes was to spray the dishes in sink to rinse off food, place the dishes in the rack in the machine, turn on the machine to do it's rinse, then do a check for chlorine after the rinse cycle. DW 11 was observed taking chlorine sample at water exit site from the machine, not directly on dishes that had just been rinsed. DW 11 was unsure where to take temperature reading for the log. DW 11 pointed to the chlorine test strip when asked about the temperature. Review of Dish Machine Temperature Log with DW 11 indicated the temperature was logged at 120 degrees farenheit (F) for that morning. Return demonstration of how DW 11 took temperature was conducted. DW 11 ran dish washing machine, took her reading on the machine's thermometer, temperature at 8:05 A.M. was 115 degrees F. Water temperature at water exit site taken independently with surveyor's thermometer with reading at 110 degrees F. DW 11 stated she took the temperature by the machine's thermometer that morning on 8/21/24. DW 11 was not sure what the appropriate temperature should be. On 8/21/24 at 8:30 A.M., a concurrent observation of the low temperature dishwasher, interview with Dietary Manager (DM), and record review of Dish Machine Temperature Log was conducted. DM observed a return demonstration of DW 11 checking temperature of water and chlorine sample after rinse. DM also placed an independent kitchen thermometer at point of rinse, while surveyor's thermometer was placed at rinse water exit site from machine. Kitchen thermometer reading was 110 degrees F inside the machine, surveyor's thermometer at rinse water at exit site was 105 degrees F. DM stated that the machine was not getting up to the appropriate temperature for rinse and they would need to use the three compartments sink for manual washing the rest of the dishes. DM stated that the importance of getting rinsing temperature to 120 degrees F was that the dishes needed to be at the temperature to get the dishware clean and disinfected. Dish Machine Temperature Log reviewed with DM. Wash: and Rinse numbers were all the same for the whole log despite having different measurements that morning. DM stated that the dishwashers were probably not taking the temperature and just writing in same number. On 8/21/24 at 8:40 A.M., a concurrent observation of low temperature dishwasher and interview was conducted with DM and DW 11. A return demonstration of DW 11 testing chlorine levels on dishware was conducted with DM observing. DW 11 took sample from exit water site from the machine. DM stated that DW 11 should have taken the sample from the clean plate after rinse. DM stated that she didn't know the parameters for chlorine disinfection. DM stated that the importance of taking the sample on the dishes was to ensure dishes were getting sanitized by chlorine. (continued on next page)

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 8/22/24 at 8:30 A.M., a concurrent observation of low temperature dishwasher and interview with DW 12 and DM was conducted. DW 12 was observed washing dishes. DW 12 asked to read temperature gauge on dish machine, temperature reading was 125 F. DW 12 observed taking chlorine sample from rinse water exit site, not directly on washed dishware. DW 12 stated that he was unaware of taking chlorine sample on the dishware. Return demonstration of chlorine sampling was done with DM observing. DW 12 stated the importance of appropriate dishwashing was to disinfect and clean the dishes for the residents, so they don't get sick. DM stated that her expectation was for her staff to take the chlorine sample on the dishware right after the dishwashing machine finished the cleaning cycle. On 8/22/24 at 8:55 A.M., an interview with the DM was conducted. The DM stated that the expectation was the dishwashers should understand the reason they take temperatures and chlorine samples, and why they document them. DM stated that it's important to understand when the numbers are off, so they know when the machine is not working appropriately and may need maintenance. DM stated the importance of dishwasher competency was to prevent food born illness from spreading via contaminated dishes. Review of policy titled DISHWASHING indicated .All dishes will be properly sanitized through the dishwasher .8. A temperature log (and chlorine log for low temperature machines) will be kept and maintained by dishwashers to assure that the dish machine is working correctly .9. The dishwasher will run the dish machine until temperature is within manufacturer's recommendations .use machine at a range of 120-140 F. The chlorine should read 50-100 PPM on dish surface in final rinse .

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 43518 Based on observation, interview and record review, the facility failed to ensure food served to all residents was in a palatable, flavorful manner that maintained the nutritional value of the menu items served. This failure had the potential to decrease residents' meal intake and contribute to weight loss. The facility census was 55. Findings: During a dining observation and interviews with residents on 8/20/24 from 9:00 A.M. to 12:45 P.M., residents' food concerns included: .Cooks can't cook grilled cheese sandwich . .Macaroni and cheese were dry . Sometimes food can be cold . .Meat is bland, noodles come with no sauce, too many carrots . .I always get broccoli. I won't eat that . . Food is cold, had no taste . .Food had no taste; meat was hard to cut . .Food was gritty, not good . .I'm a Vegetarian and they keep giving me fish . .I get food for lunch that is salty, and I'm a on renal diet .it's unhealthy . .I always get chicken or ham sandwich for my lunch sack, but would prefer peanut butter and jelly sandwich . .Food was overcooked, oversalted, water-down soups, and not enough fresh fruit . Review of the facility's menu dated 8/20/24 indicated the Regular Diet meal for lunch was: Roast turkey with gravy, bread stuffing, broccoli with garlic, wheat roll and glazed apple square. The Pureed Diet meal was pureed versions of regular diet. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 8/21/24 at 12:45 P.M., a test tray observation and interview was conducted with the Dietary Manager (DM) and the Registered Dietician (RD), for two test trays (Pureed and Regular). Menu that day on 8/21/24 for both diets included: Fish Italiano, Scalloped Potatoes, Italian Herb Vegetables, Red & [NAME] salad, and peach crisp. Temperatures of each dish was taken by DM with kitchen thermometer. Observed temperatures were as follows: Fish Italiano was 140 degrees Fahrenheit (F), Scalloped Potatoes was 140 degrees F, Italian Herb Vegetables was 135 degrees F, salad and peach crisp were served at room temp and temperature was not taken. Fish Italiano had a soft texture but was bland and needed seasoning. Scalloped potatoes were soft and bland and needed seasoning. Italian Herb Vegetables were overcooked with a mushy texture; taste was bland and needed seasoning. Pureed versions of regular diet dishes were sampled. Pureed dishes all had the consistency of applesauce and had considerably more seasoning and were not bland. DM stated that they use broth and juices from dishes to add liquid to puree. DM stated that they provided the residents on regular diet with salt and pepper and Mrs. Dash (seasoning with no sodium and with herbs) for those with limited salt diet. On 8/22/24 at 8:55 A.M., an interview with DM was conducted. DM stated that the expectation was residents should be able to eat and enjoy all their meals. DM stated residents should enjoy the flavor of the food. DM stated the importance of residents eating their meals was because residents who don't eat, can lose weight, and that can affect their health negatively. Review of facility's policy titled Resident Food Preferences dated July 2017 indicated, .9. The Food Services Department will offer a variety of foods at each scheduled meal, as well as access to nourishing snacks throughout the day and night .

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 43518 Based on observation, interview, and record review the facility failed to ensure: 1. Soy sauce and teriyaki glaze were stored per manufacturer's recommendation, 2. The low temperature dishwasher reached appropriate rinsing temperature for sanitization of dishware. These failures increased the chances of residents getting foodborne illness. Findings: 1. On 8/20/24 at 8:14 A.M., an observation of the kitchen storeroom and interview with Dietary Manager (DM) was conducted during the initial tour. Opened containers of soy sauce and teriyaki glaze were observed on a shelf in dry storeroom. Soy sauce was dated 8/6/24 and teriyaki glaze was dated 8/4/24. Review of manufacturer's recommendations on container labels indicated REFRIGERATE AFTER OPENING. DM stated that she was unaware that soy sauce and other soy based sauces needed to be refrigerated. DM disposed of sauces in the garbage. On 8/23/24 at 7:50 A.M., an interview with DM was conducted. DM stated that expectation was that her staff would read the food labels and follow the directions for storage on labels. DM stated the importance of proper food storage was to not serve the residents spoiled or contaminated food and prevent food borne illness. Review of policy titled STORAGE OF FOOD AND SUPPLIES dated 2023, indicated .11. Liquid foods .which have been opened will be tightly closed, labeled, and dated .Check food labels closely to verify if a food needs to be refrigerated once opened. 2. On 8/21/24 at 8 A.M., a concurrent observation of the low temperature dishwasher, interview with Dishwasher (DW) 11, and record review of Dish Machine Temperature Log was conducted. DW 11 was unsure where to take temperature reading for the log. DW 11 pointed to the chlorine test strip when asked about the temperature. Review of Dish Machine Temperature Log with DW 11 indicated the temperature was logged at 120 degrees Fahrenheit (F) for that morning on 8/21/24. Return demonstration of how DW 11 takes temperature was conducted. DW 11 ran machine rinse, took the reading on the machine's thermometer at 8:05 A.M. which was 115 degrees F. Water temperature at water exit site taken independently with surveyor's thermometer was 110 degrees F. DW 11 stated she took the temperature that morning by the machine's thermometer. DW 11 was not sure what the appropriate temperature should be. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 8/21/24 at 8:30 A.M., a concurrent observation of low temperature dishwasher, interview with Dietary Manager (DM), and record review of Dish Machine Temperature Log was conducted. DM observed a return demonstration of DW 11 checking temperature of water and chlorine sample after rinse. DM also placed an independent kitchen thermometer at point of rinse, while surveyor's thermometer was placed at rinse water exit site from machine. Kitchen thermometer reading was 110 degrees F inside the machine and surveyor's thermometer at rinse water exit site was 105 degrees F. DM stated that the machine is not getting up to the appropriate temperature for rinse and they would need to use the three compartment sink for manual washing for the rest of the dishes. DM stated that the importance of getting rinsing temperature to 120 degrees F was that the dishes needed that temperature to get the dishware clean and disinfected. Dish Machine Temperature Log was reviewed with DM. Wash and Rinse numbers were all the same for the whole log despite having different measurements that morning. DM stated that the dishwashers were probably not taking the temperature and just writing in same number. On 8/22/24 at 8:55 A.M., an interview with DM was conducted. DM stated that the expectation was that her dishwashing machine should reach 120 degrees F or greater. DM stated that the importance of dishwashing machine reaching a rinse temperature of 120 degrees F or greater was to make sure the dishwashing machine was working according to manufacturer's guidelines to prevent food born illness from spreading via contaminated dishes. Review of policy titled DISHWASHING indicated .All dishes will be properly sanitized through the dishwasher .8. A temperature log (and chlorine log for low temperature machines) will be kept and maintained by dishwashers to assure that the dish machine is working correctly .9. The dishwasher will run the dish machine until temperature is within manufacturer's recommendations .use machine at a range of 120-140 F. The chlorine should read 50-100 PPM on dish surface in final rinse .

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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** 43518 Based on observation, interview, and record review, the facility failed to implement and maintain infection control procedures for three (Resident 27, Resident 34 and Resident 6) of 17 residents reviewed for infection control when: 1. Oxygen tubing was not changed weekly for two residents (Resident 27 & 34) per policy and procedure . 2. CPAP mask for Resident 6 was not stored properly. These deficient practices had the potential for residents to transmit infectious microorganisms and increase the risk of infection for residents and staff. Findings: 1. a. Review of Resident 27's Admission Record indicated that Resident 27 was admitted on [DATE] for diagnoses which included Chronic Respiratory Failure (a long-term condition that makes it difficult to breathe and exchange oxygen and carbon dioxide in the body), Chronic Obstructive Pulmonary Disease (COPD-a group of lung diseases that damage the airways and other parts of the lungs, making it difficult to breathe), and Congestive Heart Failure (a long-term condition that happens when your heart can't pump blood well enough to give your body a normal supply). Review of Resident 27 Minimum Data Set (MDS-A standardized assessment tool used to evaluate the health status of residents in Medicare and Medicaid certified nursing homes) section C dated June 24, 2024 indicated a Brief Interview for Mental Status (BIMs- a test that assesses a patient's orientation, learning, and memory) score of 11, indicating moderate cognitive impairment for the resident. Review of Resident 27's physician orders dated 7/2/2024 indicated Oxygen at 2-3 LPM (Liters per minute) titrate (adjust) as needed for COPD to keep Oxygen saturation (a measure of oxygen in blood) greater than 91% . On 8/20/24 at 9:05 A.M., an observation and interview were conducted with Resident 27. Resident 27 was observed on oxygen via nasal cannula. Oxygen tubing was labeled 8/6/24 at end of tubing connected to oxygen machine. Resident 27 stated that she was unsure of when oxygen tubing was last changed or how often they changed the tubing. On 8/21/24 at 10:20 A.M., an observation and interview were conducted with Resident 27. Resident 27 stated they changed her tubing last night. No label or date on tubing was observed. On 8/22/24 at 10: 15 A.M., an observation of Resident 27's oxygen tubing was conducted. No label or date on tubing was observed. b. Review or Resident 34's Admission Record indicated that Resident 34 was admitted on [DATE] for diagnoses which included Congestive Heart Failure, Chronic Respiratory Failure, and Shortness of Breath. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 34's MDS section C dated June 28, 2024, indicated a BIMs score of 15 meaning intact cognitive abilities for the resident. Review of Resident 34's physician orders dated 5/20/24 indicated Oxygen at 2 LPM via nasal cannula (tube for oxygen that goes in your nose) PRN (as needed) SOB (Shortness of breath) (COPD) ***Keep O2 saturation > (greater than) 90% . On 8/20/24 at 9:58 A.M. an observation and interview were conducted with Resident 34. Resident was observed on oxygen via nasal cannula. Oxygen tubing was labeled 8/6/24 at end of tubing connected to oxygen machine. Resident 34 stated that staff were supposed to change the tubing every week, but she was unsure when it was last changed. On 8/21/24 at 10:15 A.M., an observation and interview were conducted with Resident 34. Resident 34 stated they changed her tubing last night. No label or date on tubing was observed. On 8/22/24 at 10: 17 A.M., an observation of Resident 34's oxygen tubing was conducted. No obvious labeling on tubing was observed. On 8/22/24 at 10:20 A.M., an interview with the Respiratory Therapist (RT) was conducted. The RT stated that she does tubing changes for nasal cannula once a week. The RT stated that she had been on emergency leave for her sister and 8/6/24 was the last day she was at facility. The RT stated that she labeled tubing with paper tape and a marker because she was in a hurry that day. The RT stated that she changed the tubing on 8/21/24 and she labeled tubing with permanent marker on the side of the tubing. Then RT stated the tubing should have been changed on 8/13/24, but she was not there to change it. The RT stated the expectation was that oxygen tubing should be changed once a week and labeled clearly with date of change. The RT stated the importance of changing and clearly labeling oxygen tubing was to help prevent infection from the tubing. On 8/22/24 at 1:35 P.M., an interview with Licensed Nurse (LN)1 was conducted. LN 1 stated the expectation was for the RT to change oxygen tubing weekly. LN 1 stated that if the RT is unavailable, LN should change the tubing, and clearly label the date tubing was changed. LN 1 stated the importance of changing tubing weekly and labeling the tubing clearly was to prevent infection from bacteria growth in the tubing. On 8/22/24 at 2:30 P.M., an interview was conducted with the DON. The DON stated the expectation was to change the oxygen tubing weekly and that it should be clearly labeled with date changed. The DON stated the importance of changing tubing weekly was to prevent infection from the tubing. On 8/23/24 at 1:45 P.M. an interview was conducted with the IP. The IP stated that the expectation was for staff to change oxygen tubing weekly and to clearly label with date of change. The IP stated that it's important to change the tubing weekly and label the date of change to prevent bacterial growth in tubing which could cause infection in the residents. Review of policy titled Policies and Practices-Infection Control dated October 2018 indicated This facility's infection control policies and practices are intended to facilitate maintaining as a safe, sanitary and comfortable environment and to help prevent and manage transmission of diseases and infections . (continued on next page)

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	055078	A. Building B. Wing	08/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Parkway Hills Nursing & Rehabilitation	7760 Parkway Drive LA Mesa, CA 91942

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	46235 2. Resident 6 was admitted to the facility on [DATE] with diagnoses including obstructive sleep apnea (OSA-a problem in which breathing pauses during sleep due to blocked airways) according to the facility's Admission Record. During an observation on 8/21/24 at 8:56 A.M., Resident 6 was in bed with a red hat covering her eyes. Resident 6 did not respond when greeted. A CPAP machine was observed on top of a plastic container with two drawers on the right side of the bed. The mask for the CPAP machine was on top of Resident 6's bed. During an observation on 8/21/24 at 11:16 A.M. Resident 6 was not in her room. Resident 6's bed was unmade, and the CPAP mask was on the floor. During an interview on 8/21/24 at 11:16 A.M. with licensed nurse (LN) 1, LN 1 stated Resident 6 applied the CPAP mask on at night and removed it in the morning. LN 1 stated the licensed nurses were responsible for keeping the mask inside a plastic bag when not in use for infection control and the respiratory therapist (RT) was responsible for cleaning and maintaining the CPAP machine. A concurrent observation and interview was conducted with the RT on 8/21/24 at 11:34 A.M. Inside Resident 6's room, Resident 6's CPAP mask was on top of a plastic container with two drawers. The RT stated Resident 6 refused to have the mask to be stored in a plastic bag. The RT stated the tubing and mask were cleaned weekly and they were last cleaned last Tuesday, 8/13/24. The RT stated she did not clean the tubing and mask yesterday, 8/20/24 and there was no documentation in Resident 6's records when she last cleaned them. An interview with Resident 6 was conducted on 8/22/24 at 3:45 P.M. Resident 6 was in bed and stated she never told staff not to store her CPAP mask in a plastic bag. During an interview on 8/23/24 at 11:23 A.M. with the DON, the DON stated the CPAP mask should be stored in a plastic bag for infection control. During a review of the facility's policy and procedure (P&P) titled, Policies and Practices-Infection Control, dated October 2018, the P&P indicated, . The objectives of our infection control policies and practices are to . Provide guidelines for the safe cleaning and reprocessing of reusable resident-care equipment . During a review of the facility's policy and procedure (P&P) titled, CPAP/BIPAP Support, dated March 2015, the P&P did not provide guidance to staff regarding storage of CPAP masks when not in use.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48263 Based on observation, interview, and record review, the facility failed to offer and/or administer an updated pneumococcal vaccine for two of five residents (Resident 31 and Resident 37) reviewed for immunization. These failures increased the risk to compromise the health and well-being of Resident 31 and Resident 37 with respiratory infections and other complications associated with pneumonia (a respiratory infection caused by bacteria, virus or fungi that causes the lungs to be inflamed making it hard for oxygen to circulate in the blood stream that can cause discomfort and difficult to breath). Cross Reference F641 Findings: 1. A review of Resident 31's Admission Record indicated Resident 31 was readmitted to the facility on [DATE] with diagnoses which included a history of congestive heart failure (a long-term condition that occurs when the heart is not able pump enough blood to meet the body's needs). A record review of Resident 31's Minimum Data Set (MDS- a nursing assessment tool that is used to develop a plan of care) dated 5/21/24, indicated a Brief Interview for Mental Status (BIMS- developed by reviewing the resident's status during the prior seven-day period) score of 15 points out of 15 possible points which indicated Resident 31 was cognitively (pertaining to memory, judgement, and reasoning ability) intact. On 8/23/24 at 9:48 A.M., a concurrent interview and record review was conducted with the Infection Prevention (IP) nurse. The IP stated that Resident 31 had a consent form dated 1/20/24 during vaccine season (October 1 through March 31 annually) 2023-2024 but did not receive an updated pneumonia vaccine (medication to prevent pneumonia) according to the Centers for Disease Control (CDC-government agency monitoring infections) vaccine recommendations. The IP nurse stated it was important to offer and administer an updated pneumonia vaccine to prevent pneumonia because Resident 31 had a history of pneumonia. On 8/23/24 at 10 A.M., a record review was conducted of Resident 37's electronic vaccination record. There was no documentation of an updated pneumonia vaccine administered and/or refusal to consent. On 8/23/24 at 11:29 A.M., an interview was conducted with Resident 31, in Resident 31's room. Resident 31 stated he was offered and received a COVID-19 (coronavirus: A highly contagious respiratory disease caused by the SARS-CoV-2 virus) and Flu (influenza: contagious respiratory disease caused by different strains of viruses) vaccine but was not offered or given an updated pneumonia vaccine. Resident 31 stated, I'd consent to it if they offered me an updated pneumonia vaccine. On 8/23/24 2:30 P.M., an interview with the DON was conducted. The DON stated it was important that all residents be offered and administered vaccine if consented. The DON stated Resident 31 should have been administered an updated pneumonia vaccine to prevent pneumonia and other respiratory complications. (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of facility's policy and procedure titled PNEUMOCOCCAL VACCINE revised October 2023, indicated .4. Pneumococcal vaccines are administered to residents (unless medically contraindicated, already given, or refused) per our facility's physician-approved pneumococcal vaccination protocol .7. Administration of the pneumococcal vaccines are made in accordance with current Centers of Disease Control (CDC) recommendations at the time of the vaccination . 2. A review of Resident 37's Admission Record indicated Resident 37 was readmitted to the facility on [DATE] with diagnoses which included a history of epilepsy (also known as seizures - uncontrolled jerking, blank stares, loss of consciousness) who required nutritional and medication administration through a G-tube (GT -gastronomy tube: a surgical opening on the abdomen for nutritional and/or medication administration). A record review of Resident 37's MDS dated [DATE] indicated that Resident 37 was unable to participate with a cognitive (the mental processes that take place in the brain, including thinking, attention, language, learning, memory, and perception) brief interview for mental status and indicated that his cognitive skills for daily decision making was severely impaired (never/rarely made decisions). On 8/23/24 at 9:48 A.M., a concurrent interview and record review was conducted with the IP nurse. The IP stated that Resident 37 had a consent form dated 10/16/23 for vaccine season (October 1 through March 31 annually) 2023-2024 but did not have a check mark for consent or refusal for pneumonia vaccine. The IP nurse stated that the pneumonia vaccine was not offered to Resident 37 if the refusal section was left blank and unchecked. The IP nurse stated it was important to offer an updated pneumonia vaccine to Resident 37 because of his current health status with the dependence of a gastronomy tube (G-tube: a surgical opening on the abdomen for nutritional and/or medication administration) that put Resident 37 as a high-risk potential for pneumonia infections and associated respiratory complications. On 8/23/24 at 10 A.M., a record review was conducted of Resident 37's electronic vaccination record. There was no documentation of an updated pneumonia vaccine administered and/or refusal to consent. On 8/23/24 2:30 P.M., an interview with the DON was conducted. The DON stated it was important that all residents be offered and administered vaccines if consented. The DON stated Resident 37 should have been administered an updated pneumonia vaccine to prevent pneumonia and other respiratory complications. A review of facility's policy and procedure titled PNEUMOCOCCAL VACCINE revised October 2023 indicated .4. Pneumococcal vaccines are administered to residents (unless medically contraindicated, already given, or refused) per our facility's physician-approved pneumococcal vaccination protocol .7. Administration of the pneumococcal vaccines are made in accordance with current Centers for Disease Control and Prevention (CDC) recommendations at the time of the vaccination .

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F 0912 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide rooms that are at least 80 square feet per resident in multiple rooms and 100 square feet for single resident rooms. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43518 Based on observation and review of the Client Accommodations Analysis (document with measurements of the square footage of the useable living space of individual resident rooms and approved capacities), the facility failed to provide the minimum of 80 square feet (sq. ft.) per resident in 4 of 28 resident rooms. Findings: The facility's Analysis of Accommodations was reviewed. Resident rooms [ROOM NUMBERS] each accommodated two resident occupancy providing 143 total square feet of space per room. Each room provided 71.5 of sq. ft. per resident. Resident room [ROOM NUMBER] accommodated three residents, providing a total of 221 sq. ft. of room space with 73.66 sq. ft. of room space per resident. Resident room [ROOM NUMBER] accommodated four resident occupancy providing a total 304 sq. ft. per room with 76 sq. ft. per resident. The variations in room size requirements are not observed to adversely affect the resident's health, safety, quality of care or quality of life during the survey. The Department recommends continuance of the room size variance/waiver for Rooms 2, 4, 6 and 21.