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	09/24/2025

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 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. Based on observation, interview and record review, the facility failed to ensure the Dietary Manager (DM) had the required education or experience to effectively manage the Food Service department. This failure had the potential to place 52 residents at risk for foodborne illness. Cross reference: F806, F812, F813Findings: An interview was conducted with the DM on 9/22/25 at 9:45 A.M. The DM stated she had been employed as the DM for approximately 18 months. The DM stated she did not have a degree in food service management, or a Certified Dietary Manager (CDM) credential. The DM stated she did not have experience as a food service manager from any other facility. The DM stated she had been promoted into her current job by a previous manager. A record review of the DM's employee file was conducted on 9/22/25. An undated, unsigned job description, titled Certified Dietary Manager, was in the file. Per the job description, The primary purpose of this position is to plan, organize, develop and direct the operations of the food and nutrition services department in accordance with current federal, state and local standards .Education: Must possess, as a minimum, a bachelor's degree in nutrition, dietary management or related field .Specific Requirements: Must be a Certified Dietary Manager . An undated, unsigned document, titled License or Certification Verification Form, was in the HR file. The document was blank and did not include a license or certification number. A resume for the DM listed her education as a high school graduate, currently enrolled in college courses as of February 2022. No course of study or graduation date for college was listed. No credential or license was listed on the resume or within the employee file. An interview was conducted with the Administrator (Admin) on 9/22/25 at 1 P.M. The Admin stated the DM reported to her. Per the Admin, the DM had been promoted by her predecessor. The Admin stated she was unaware the DM did not have a license or certificate to fulfill the job qualifications. The Admin stated the lack of training and education had the potential to impact the quality of the food service provided to the residents.

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure two of three residents reviewed for oxygen therapy had:Oxygen saturation levels (the amount of oxygen in the blood) routinely monitored and documented (Resident 3), and,A physician's order for oxygen therapy was obtained prior to administration (Resident 7). These failures had the potential for Residents 3 and 7 to receive oxygen when it was not required, resulting in the possibility of dependency. Findings: 1. Resident 3 was admitted to the facility on [DATE], with diagnoses which included chronic obstructive pulmonary disease (COPD-permanent damage to the lungs which affects airflow and gas exchange), per the facility's admission Record. An observation and interview was conducted with Resident 3 on 9/21/25 at 8:51 A.M. Resident 3 was sitting up in bed with a nasal cannula (a plastic tube that delivers oxygen to the nose) inserted in his nares. Resident 3 stated he had trouble breathing sometimes and normally gets 2 liters of oxygen. An oxygen condenser (a machine that delivered oxygen) was on the floor next to the bed. On 9/22/25, Resident 3's clinical record was reviewed. According to the physician's order, dated 9/8/25, oxygen two liters per minute via nasal cannula to keep oxygen saturation rate above 90%, (normal 97% - 99%) as needed. The facility's Weights and Vital Summary Task sheet for documenting oxygen saturation rates from 8/4/25 through 9/23/25 were reviewed. Oxygen saturations were documented 22 times out of 51 opportunities (if completed 1 time a day). Resident 3's oxygen saturation was recorded on room air 17 times out of 22 opportunities and was 95% or above with the exception of once. The facility's Medication (MAR) and Treatment Administration Records (TAR) from 8/4/25 through 9/23/25 were reviewed with no indication if oxygen was being administered or not. Observations were conducted of Resident 3 in bed, receiving two liters of oxygen on 9/22/25 at 2:44 P.M., and 3:14 P.M, with no documented evidence of oxygen saturation levels for 9/22/25. An observation and interview was conducted with Resident 3 in his room on 9/23/25 at 8:15 A.M. Resident 3 was sitting up in bed receiving two liters of oxygen via nasal cannula. Resident 3 had a portable pulse oximetry (an external device used to check oxygen saturations) on his bedside table. Resident 3 stated he liked to check his own oxygen saturation and demonstrated how the device was used. Resident 3 applied the finger device, which displayed an oxygen saturation rate of 89% after being off oxygen for three minutes. Resident 3 reapplied the nasal cannula to his nose afterwards. There was no documented evidence of oxygen saturation levels for 9/23/25. An interview was conducted with Licensed Nurse 16 (LN 16) on 9/23/25 at 8:48 A.M. LN 16 stated oxygen saturation levels should be checked every shift, to determine if prn (as needed) oxygen was required. LN 16 stated oxygen saturations levels should be documented in the Task section and also in the Pulmonary (lung) section of the electronic record. LN 16 stated staff who provided respiratory treatments documented all of their assessments in the Pulmonary section. An interview and record review was conducted with LN 17 on 9/23/25 at 8:53 A.M. of Resident 3's (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Pulmonary assessments. LN 17 stated he checked oxygen saturation levels and lung sounds during his Pulmonary assessments of residents. LN 17 stated certified nursing assistants (CNAs) also check oxygen saturation levels every shift and document their results in the Task section of the resident's electronic record. LN 17 stated since Resident 3 was on prn oxygen, if the saturations were 90% or below, they should be documenting the saturation levels every shift (three times a day). LN 17 stated during his pulmonary treatments he also checked the saturations levels and documented the level before applying oxygen, if needed. LN 17 reviewed Resident 3's saturation levels in the Pulmonary section of the electronic record and stated the saturation levels were not there, and they should be. LN 17 stated the saturations levels were important to determine if Resident 3 required oxygen or not. LN 17 stated if Resident 3 received oxygen when it was not required, he could become more dependent on oxygen. LN 17 stated if the physician reviewed Resident 3's electronic record for oxygen saturation levels, it would not provide an accurate picture of the resident's current pulmonary status. An interview and record review was conducted with the Director of Nursing (DON) of Resident 3's pulmonary documentation on 9/23/25 at 9:06 A.M. The DON stated since Resident 3 was on prn oxygen to keep saturation levels above 90%, his oxygen saturation level should be checked on room air every shift and documented. The DON stated if Resident 3's oxygen saturation levels were above 90% and he was still receiving oxygen, there was the potential for Resident 3 to become dependent on the oxygen. The DON stated oxygen saturation levels and when oxygen was applied, should be documented in the Pulmonary section of the electronic record. The DON reviewed the Pulmonary section for Resident 3 and stated the oxygen saturation levels should be documented, but she could not see that they were. A follow up interview was conducted with LN 17 at 9/23/25 at 9:30 A.M. LN 17 stated he realized the Pulmonary section of Resident 3's electronic record was not saving the documented oxygen saturation levels, and they just realized there was a glitch in the system that needed to be corrected. LN 17 stated it as important to have documented oxygen saturation levels so the physician could analyze Resident 3's pulmonary status and change orders as needed. According to the facility's policy, titled Pulse Oximetry (Assessing Oxygen Saturation), dated October 2010, .1. Review the physician's orders.Documentation: The SaO2 (oxygen saturation) flow sheet should be placed in the medical record. In addition, the following information should be recorded in the resident's medical record: 1. The date and time the procedure was performed. 2. Any unusual findings and the action taken. According to the facility's policy titled Oxygen Administration, dated October 2010, .1. Verify that there is a physician's order.Documentation: 1. The date and time that the procedure was performed.5. The reason for the prn (as needed) administration. 2. Resident 7 was admitted to the facility on [DATE], with diagnoses which included chronic obstructive pulmonary disease, per the facility's admission Record. On 9/21/25 at 9:24 A.M., an observation during the initial tour was conducted. Resident 7 had the oxygen nasal cannula delivered at three liters per minute (LPM) via oxygen concentrator. Resident 7 did not respond when her name was called. On 9/22/25, a record review was conducted. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	There was no physician's order of oxygen for Resident 7. A form, titled Pulmonary Functioning/Monitoring dated 9/21/25, indicated Resident 7 was on continuous flow of three liters of oxygen per minute for COPD. On 9/22/25 at 9:27 A.M. and 1:42 P.M., a follow-up observation of Resident 7 was conducted. Resident 7 laid in bed, with her eyes closed and did not respond when her name was called. Resident 7 had the oxygen set at three LPM via nasal cannula. On 9/22/25 at 1:59 P.M., an interview was conducted with Certified Nursing Assistant (CNA) 12. CNA 12 stated Resident 7 was always on oxygen. On 9/23/25 at 9:32 A.M., a joint observation of Resident 7, a review of Resident 7's clinical record and an interview was conducted with LN 11. Resident 7 was in bed with the oxygen cannula on top of the oxygen concentrator. LN 11 stated Resident 7 had a prn for oxygen. LN 11 stated Resident 7 had a change in condition (a medical complication) and was placed on oxygen. LN 11 stated there was no physician's order for oxygen in Resident 7's clinical record. LN 11 stated whatever was administered to the resident, must be a physician's order because oxygen was considered a medication. On 9/24/25 at 9:16 A.M., an interview was conducted with the DON. The DON stated the expectation was when the resident had a change in condition and needed oxygen, the LNs should have obtained an order from the physician because oxygen was considered a medication and LNs should not administer any medications without physician's order. A review of the facility's policy on Oxygen Administration revised October 2010, indicated, The purpose of this procedure is to provide guidelines for safe oxygen administration.1. Verify that there is a physician's order for this procedure. Review the physician's orders.for oxygen administration.

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. Based on observation, interview and record review, the facility failed to ensure alternate food items were of equal nutritive value. This failure had the potential to place residents at risk for nutritional deficits. Findings:An observation of the kitchen tray line was conducted on 9/23/25 starting at 11:20 A.M. Trays were being prepared for 52 residents for lunch. The following items were served or prepared during the tray line: 1. [NAME] (CK 2) removed a plastic-covered chef salad from the refrigerator, and placed the salad on a resident tray. The chef salad contained a hard boiled egg, lettuce, cheese, turkey and ham. 2. CK 2 prepared a sandwich from two pieces of white bread and two slices of what appeared to be American cheese. CK 2 then grilled the sandwich in butter until browned, then placed the sandwich on a resident tray. 3. CK 2 prepared a quesadilla from a medium sized flour tortilla and a handful of shredded cheese. CK 2 browned the quesadilla in an oiled pan, then plated the quesadilla and placed it on a resident tray. No recipes or measuring utensils were visible or in use by CK 2. An interview was conducted with CK 2 on 9/23/25 at 11:50 A.M. Per CK 2, the alternative food items were offered daily in case the residents did not like the foods offered on the main menu. CK 2 stated she had not used a recipe, and had not measured or weighed the items. CK 2 stated she should have measured or weighed the cheese and meat for the salads and the sandwiches, but she did not have a scale. A concurrent observation and interview was conducted with the Registered Dietitian (RD) on 9/23/25 at 12 P.M. Per the RD, it was important to measure and weigh the ingredients for all recipes to ensure the residents were getting protein and calories equal to that provided by the main entree. The RD pulled a food scale out of a drawer to demonstrate for CK 2. A record review was conducted on 9/23/25. A facility recipe for chef's salad indicated each salad was to have one ounce of cooked turkey, a half ounce of ham, a half ounce of cheese, and a hard cooked egg. A facility recipe for grilled cheese indicated each sandwich was to have two ounces of cheese, and contained the note, Be sure to weigh cheese .Sliced cheese may not weigh one ounce per slice, make sure to weigh cheese to know how many slices equal two ounces .If using shredded cheese, a half cup equals two ounces of cheese - Do not use American Cheese . A facility recipe for cheese quesadilla indicated to use a half cup of shredded cheese per serving. Per a facility policy, dated 2023 and titled Portion Control, To be sure portions served equal portion sizes listed on the menu, portion control equipment must be used .A diet scale should be used .

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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. Based on observation, interview and record review, the facility failed to ensure kitchen sanitation and proper food storage was implemented in a manner that lessened the risk for foodborne illness when: 1. Food preparation areas, food storage containers and a tabletop can opener were visibly dirty, 2. Food in the kitchen was not labeled with opened date, use by date, or dispose date,3. Foods in the storeroom were not labeled with opened date or use by date, and4. Overhead light fixtures in the kitchen were rusted and dirty. These failures had the potential to cause foodborne illness to a population of 52 residents who received food from the kitchen. Findings: A kitchen tour was conducted on 9/21/25 at 8:39 A.M. with [NAME] (CK) 1. 1. The tile ledge near the hand wash sink, as well as a chemical dispenser box were covered with a thick, dark greasy layer of what appeared to be dirt. A window ledge over a utility sink had a thick dark layer of the same substance. A table top can opener had food debris embedded into the grooves of the can opener, as well as the tabletop can opener holder. A plastic food storage container with salt in it, located on a shelf over the food preparation area, had visible dried food debris on the outside of the container. CK 1 stated the area should be clean so the food would not become contaminated. CK 1 stated the can opener and salt container should have been removed from the service area and cleaned. 2. A large metal bowl on the countertop, containing approximately 25 dinner rolls was covered with plastic wrap. No label was on the container indicating the date prepared. Per CK 1, the dinner rolls should have a label indicating the date the rolls were prepared, and when to discard them. 3. In the storage room, a large bag of oatmeal was observed, placed on a metal rack. The bag contained approximately 20 pounds of oatmeal. The top of the bag was rolled down and not sealed. No label was evident, no date indicated when the oatmeal had been opened or when it should be discarded. Two large plastic buckets containing chicken and beef base were on the same rack, with the manufacturers' product label but no other indication of opened date or dispose date. The lids on the soup bases were not fully closed, leaving the contents partially exposed. Per CK 1, the oatmeal and the soup bases should have been transferred to a covered, sealed container with all important dates on a label. CK 1 stated it was important to keep foods in airtight containers to prevent bugs and other pests. 4. A kitchen observation and RD interview was conducted on 9/23/25 at 11 A.M. Ceiling light fixtures over the food prep areas had what appeared to be rust or dark, solid debris on the metal ends. The light fixtures were suspended over the food carts, where trays were being prepared for the residents' lunch meal. The RD stated maintenance staff should have noticed the rust or debris and either repaired or replaced the light fixture. The RD stated it was the DM's role, as well as her own, to follow up on the light fixtures, and to report the concerns to the Administrator. The RD stated she had not previously identified the light fixtures as a food safety issue, and she should have notified the Admin. An interview was conducted on 9/24/25 at 1:30 P.M. with the DM and the RD. Per the DM, she was responsible for the sanitation and food storage in the kitchen. The DM stated the kitchen tile and can opener should have been cleaned but had been missed by staff. The DM stated all foods should be labeled and dated with a received date and as appropriate, an opened date and discard date. The DM stated kitchen staff currently only wrote a received date on the product labels, which could lead to miscommunication about food safety. The RD stated she did monthly audits of sanitation and product labeling with the last audit done approximately three weeks earlier. The RD stated she provided oversight of the kitchen and was responsible for reporting any concerns to the Admin. The RD stated she had not identified any problems with sanitation, labeling or food safety during her recent kitchen audit. An interview was conducted with the Admin on 9/24/25 at 2 P.M. The Admin stated the DM and the RD reported to her. The Admin stated neither the DM nor the RD had informed her of any sanitation issues or maintenance concerns within the kitchen. The Admin stated her expectation was for managers to report their concerns to her so that they could be resolved promptly. Per a facility policy, (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	dated 2023 and titled Sanitation, .The FNS Director [DM] is responsible for.sanitation in food service.The FNS Director will report any equipment needing repair to maintenance.all utensils, counters, shelves, and equipment shall be kept clean, maintained in good repair. According to a facility policy, dated 2023 and titled Labeling and Dating of Foods, All food items in the storeroom, refrigerator, and freezer need to be labeled and dated.Newly opened food items will need to be closed and labeled with an open date and used by the date that follows the various storage guidelines.All prepared foods need to be covered, labeled and dated. Per a facility policy, dated 2023 and titled Storage of Food and Supplies, Food and supplies will be stored properly and in a safe manner.Dry bulk foods (flour, sugar, dry beans, food thickener, spices, etc.) should be stored in seamless metal or plastic containers with tight covers, or in bins which are easily sanitized .Bins/containers are to be labeled, covered and dated.All foods will be dated - month, day, year.Dry food items which have been opened, such as pudding, gelatin, biscuit mix.will be tightly closed, labeled and dated.

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. Based on observation, interview, and record review, the facility failed to ensure the interdisciplinary team (IDT, a group of healthcare professionals from different disciplines involved in providing care to the residents) assessed and documented self-administration of medications kept at bedside was clinically appropriate for one of 15 sampled residents (Resident 29). This failure had the potential for Resident 29 to experience negative health outcomes, including increased risk of infections and not to receive the full therapeutic benefits of his medications.Findings:A review of Resident 29's clinical record indicated he was admitted to the facility with diagnoses such as burn of second degree [a burn that causes injury, blistering, pain and swelling to the outer and middle layers of the skin]. including the right eye.During a concurrent observation and interview with Resident 29 on 9/23/25 at 9:29 A.M., Resident 29 stated he sometimes.[ran] out of Tegaderm [a transparent dressing used to cover and shield wounds], which he wore underneath his eyepatch. Resident 29 stated he also ran out of his lubricating eye ointment and eye drops at times. Resident 29 stated without his lubricating eye drops and eye ointment, the Tegaderm dressing would stick to his right eyeball because he did not have an eyelid. Resident 29 stated when that occurred, the Tegaderm would rip the top layer of his eye leading to pain and bleeding. Resident 29 reached for a bin in his room full of medications and supplies. Resident 29 laid out his medications and explained how he self-administered his eye treatment. Resident 29 stated he irrigates (to wash or remove debris) film on his eye using a saline (salt water) flush and sponge(s). Resident 29 stated the saline flush stung his eye, so he used Refresh Tears lubricating eye drops to relieve the burning sensation. Resident 29 stated he followed that with moxifloxacin (an antibiotic) eye drops. Resident 29 said he had bacterial conjunctivitis (or pink eye, an infection on the outer layer of the eye) on and off for two years. Resident 29 stated he instilled GenTeal Tears lubricating eye ointment after the moxifloxacin eye drops and then applied Tegaderm. Asked if he waits between instilling any of the eye drops, Resident 29 stated, I don't have to wait because I don't have any other antibiotics to put on. I only have [moxifloxacin]. Resident 29 stated he had been self-administering his eye treatment four times daily for about a year. During an interview with the Treatment Nurse (TN) on 9/24/25 at 9:59 A.M., the TN stated she no longer provides Resident 29 with treatments as he prefers to self-administer his ointment and wound care for [his] right eye. The TN stated Resident 29 informed staff when he was low on medications and supplies for his right eye treatment. The TN stated Resident 29 was particular about Tegaderm, he wants 3M [brand] Tegaderm. If it's not 3M, he'll refuse. The TN stated Resident 29 may have done his eye treatment more frequently than prescribed. The TN stated, I think he does it more than four times [a day]. In the computer, it's four times. The order is every six hours. I believe he does his wound care more often.A review of Resident 29's clinical record indicated he had a form titled, Self-Administration of Medications, dated 10/6/22, which indicated, Does the resident want to self-administer medications? The option c. No. was selected.During an interview with the Director of Nursing (DON) on 9/24/25 at 1:21 P.M., the DON stated Resident 29 wasn't supposed to self-administer. We don't have an order for it. It may have come from his eye appointment. I don't know. He shouldn't be self-administering. The DON stated, he shouldn't have [medications] at bedside. The DON stated, he shouldn't be self-administering without appropriate documentation and assessment because if he's not assessed, we don't know if he's doing it the right way, following physician orders, for safety.A review of the facility's policy and procedure (P&P) titled, Self-Administration of Medications, revised 2/2021, indicated, .1.the interdisciplinary team (IDT) assesses each resident's cognitive and physical abilities to determine whether self-administering medications is safe and clinically appropriate for the resident.A review of the facility's P&P titled, Administering of Medications, revised 4/2019, indicated, .26. Residents may self-administer their own medications only if the Attending Physician, in conjunction with the Interdisciplinary Care Planning Team, has determined that they have the decision-making capacity to do so safely.A review of the facility's P&P titled, Instillation [method (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	used to put a liquid into the body slowly] of Eye Drops, revised 1/2014, indicated, .General Guidelines.4. When administering two or more different eye drops allow three to five minutes between each application.

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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** Based on observation, interview, and record review, the facility failed to ensure a comprehensive resident-centered care plan (detailed plan with information about a patient's treatment, goal, and interventions) was implemented for one of two sampled residents (Resident 8) reviewed for pain management. This failure had the potential to affect resident's care needs. Cross Reference F 697.Findings: Resident 8 was readmitted to the facility on [DATE] with diagnoses which included cancerous tumor of the right breast and chronic pain, per the facility's admission Record. On 9//21/25 at 8:22 A.M., an observation and an interview with Resident 8 was conducted in her room. Resident 8 laid in bed and was watching a television show. Resident 8 stated she had missed four doses of her pain medication because staff had informed her the facility ran out. Resident 8 stated she was upset because she was in pain. On 9/22/25, a record review was conducted. Resident 8's History and Physical (H & P), dated 7/17/25, indicated she had the capacity to understand and make decisions. A physician's order, dated 8/22/25, indicated Resident 8 was to receive oxycodone (a controlled medication for pain) every six hours for pain management. A care plan, dated 8/4/24, indicated Resident 8 had chronic pain, and interventions were to administer oxycodone (a pain medication) as ordered. On 9/22/25 at 2:15 P.M., an interview was conducted with Certified Nursing Assistant (CNA) 11. CNA 11 stated he was taking care of and was familiar of Resident 8. CNA 11 stated Resident 8 was alert, oriented and knew what was going on. CNA 11 stated Resident 8 talked about her pain a lot and talked about not feeling good. CNA 11 stated Resident knew when her pain medication was due. CNA 11 stated Resident 8 mentioned she missed some doses of her pain medications. On 9/22/25 at 2:51 P.M., an interview and record review for Resident 8 was conducted with Licensed Nurse (LN) 1. LN 1 stated she was familiar with Resident 8. LN 1 stated Resident 8 had scheduled pain medication to be given every six hours and usually had pain. LN 1 reviewed Resident 8's Pain care plan, and stated the interventions to administer pain medications were not implemented. On 9/24/25 at 9:16 A.M., an interview was conducted with the Director of Nursing (DON). The DON stated the expectation was to implement Resident 8's care plan to manage her pain. A review of the facility's policy titled, Care Plan, Comprehensive Person-Centered, revised March 2022 indicated, A comprehensive, person-centered care plan that includes measurable objectives.to meet the resident's physical, psychosocial.needs is developed and implemented for each resident.

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	09/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure a pain medication was available for one of two residents reviewed for pain management (Resident 8). This failure had the potential to cause the resident unnecessary pain, negatively affecting the resident's quality of life. Cross Reference to F 656.Findings: Resident 8 was readmitted to the facility on [DATE] with diagnoses which included cancerous tumor of the right breast and chronic pain, per the facility's admission Record. On 9//21/25 at 8:22 A.M., an observation and an interview with Resident 8 was conducted in her room. Resident 8 laid in bed and was watching a television show. Resident 8 stated she had missed four doses of her pain medication because staff had informed her the facility ran out. Resident 8 stated she was upset because she was in pain. On 9/22/25, a record review was conducted. Resident 8's History and Physical (H & P), dated 7/17/25, indicated she had the capacity to understand and make decisions. A physician's order, dated 8/22/25, indicated Resident 8 was to receive oxycodone (a controlled medication for pain) every six hours for pain management. On 9/22/25 at 2:15 P.M., an interview was conducted with Certified Nursing Assistant (CNA) 11. CNA 11 stated he was taking care of and was familiar of Resident 8. CNA 11 stated Resident 8 was alert, oriented and knew what was going on. CNA 11 stated Resident 8 talked about her pain a lot and talked about not feeling good. CNA 11 stated Resident knew when her pain medication was due. CNA 11 stated Resident 8 mentioned she missed some doses of her pain medications. On 9/22/25 at 2:51 P.M., an interview and record review for Resident 8 was conducted with Licensed Nurse (LN) 1. LN 1 stated she was familiar with Resident 8. LN 1 stated Resident 8 had scheduled pain medication to be given every six hours and usually had pain. Resident 8's Medication Administration Record (MAR) for September 2025 was reviewed. LN 1 stated Resident 8 did not receive three doses of scheduled pain medications on 9/19/25 at 11 P.M., 9/20/25 at 5 A.M. and 9/20/25 at 11 A.M. LN 1 stated the pain medication was not available. LN 1 stated Resident 8 had mentioned to her she wanted to go out on a pass but was in pain so she would just stay at the facility. LN 1 stated Resident 8 was in hospice and the hospice facility supplied Resident 8's medications. LN 1 stated it was important to have good communication with the hospice to ensure pain medications were ordered and available. On 9/22/25 at 3:13 P.M., a telephone interview was conducted with the hospice LN (HLN). The HLN stated the facility should have informed hospice when pain medication were running low to ensure the medications were delivered and available. On 9/24/25 at 9:16 A.M., an interview was conducted with the Director of Nursing (DON). The DON stated the expectation was to make sure pain medications were available for Resident 8 for pain control and management. A review of the facility's policy titled, Pain Assessment and Management, revised April 2025, indicated, .The medication regimen is implemented as ordered .

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	09/24/2025

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on observation, interview, and record review, the facility failed to ensure safe and effective pharmaceutical services when:1. Random controlled medication (medications with a high abuse potential) use audit for five of six sampled residents (Residents 6, 19, 26, 27 and 52) indicated medications were signed out of the controlled drug record (CDR, count sheet used to track controlled medications), but were not documented on the Medication Administration Record (MAR - section of the medical record where all medications given to the resident are recorded to ensure patient safety) to indicate they were administered to the residents. This failure had the potential for diversion (unlawful distribution or use), mismanagement of controlled medications and inadequate narcotic accountability, healthcare professional clinical decision-making based on an incomplete medical record which could result in adverse resident outcomes, and the potential to not meet the needs of the residents in the facility. 2. Expired medications were not removed from stock in one of one Medication Rooms for two residents (Residents 7 and 29). This failure had the potential for Residents 7 and 29 to receive deteriorated (reduced quality) and ineffective medications. Findings:1. During an inspection of the Long Hall Medication Cart conducted with Licensed Nurse (LN) 6 on 9/21/25 at 3:06 P.M., the CDRs for three random residents receiving PRN (as needed) controlled medications were requested for review. Additionally, three other CDRs from the Short Hall Medication Cart were requested for review on 9/22/25 at 10:31 A.M. from LN 1. a) A review of Resident 27's medical record indicated an order for hydrocodone-acetaminophen (a controlled medication used to manage pain) 5/325 milligram (mg, unit of measurement) tablet - give one tablet by mouth every 4 hours as needed for moderate to severe pain, dated 8/15/25. During a concurrent interview and record review with the Director of Nursing (DON) on 9/22/25 at 1:47 P.M., a review of Resident 27's CDR for hydrocodone-acetaminophen 5/325 mg and September 2025 MAR indicated the nursing staff signed out of the CDR, but did not document the medication administration on one occasion: 9/18/25 at 8:30 A.M. The DON confirmed there was no documentation on the MAR on 9/18/25 at 8:30 A.M. and stated, I've already looked for this one and couldn't find it. b) A review of Resident 6's medical record indicated an order for hydrocodone-acetaminophen 5/325 mg tablet - give one tablet by mouth every 6 hours as needed for moderate to severe pain, dated 1/2/25. During a concurrent interview and record review with the DON on 9/22/25 at 1:51 P.M., Resident 6's CDR for hydrocodone-acetaminophen 5/325 mg, and MARs dated May 2025 and July 2025 were reviewed. The CDR indicated the nursing staff signed out one tablet of hydrocodone-acetaminophen 5/325 mg, but did not document the medication administration on the following days: 5/31/25 at 6 A.M. 7/12/25 at 9 A.M. 7/23/25 at 2:48 P.M. The DON confirmed the lack of documentation in the medical record. The DON stated, I'm not seeing May 31st [2025]. The DON stated, I'm not finding it.neither one of those, regarding the 7/12/25 and 7/23/25 entries. c) A review of Resident 52's medical record indicated an order for oxycodone (a controlled medication used to manage pain) 5 mg tablet - give one tablet by mouth every 6 hours as needed for moderate pain (breakthrough dose), dated 9/13/25.During a concurrent interview and record review with the DON on 9/22/25 at 1:54 P.M., Resident 52's CDR for oxycodone 5 mg and September 2025 MAR were reviewed. Resident 52's CDR indicated nursing staff signed out one tablet of oxycodone 5 mg for administration, but did not document the medication administration on four occasions: 9/19/25 at 5 A.M.9/19/25 at 12 P.M.9/20/25 at 12 A.M.9/21/25 at 12 A.M. The DON confirmed she could not find any documentation of administration on Resident 52's September 2025 MAR for the above dates and times. The DON stated, I looked for those yesterday [9/21/25] and I couldn't find it.d) A review of Resident 26's medical record indicated orders for oxycodone 5 mg tablet, give one tablet by mouth every 4 hours as needed for moderate pain (5-6 level pain out of 10, 0 being no pain and 10 being the worst pain imaginable), dated 9/14/25. Resident 26 also had an order for oxycodone 5 mg tablet - give two tablets by mouth every 4 hours as needed for severe pain (7-10 (continued on next page)

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	055078	A. Building B. Wing	09/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	level pain out of 10), dated 9/14/25.During a concurrent interview and record review with the DON on 9/22/25 at 1:54 P.M., Resident 26's CDR for oxycodone 5 mg and September 2025 MAR were reviewed. Resident 26's CDR indicated nursing staff signed out two tablets of oxycodone 5 mg for administration, but did not document the medication administration on one occasion: 9/20/25 at 5 A.M.The DON confirmed the lack of documentation in the medical record and stated, No, I can't find it either.e) A review of Resident 19's clinical record indicated orders for morphine (a controlled medication used to manage pain), including morphine 100 mg/5 mL (milliliters, a unit of measurement) - give 0.25 mL every 4 hours as needed for mild pain or dyspnea (difficulty breathing), dated 2/20/25 and discontinued on 9/10/25. During a concurrent interview and record review with the DON on 9/22/25 at 2:02 P.M., Resident 19's CDR for morphine 100 mg/5 mL and MARs dated May 2025 and September 2025 were reviewed. Resident 19's CDR indicated nursing staff signed out 0.25 mL of morphine for administration, but did not document the medication administration on three occasions: 5/26/25 at 3:09 P.M.5/27/25 at 9:30 A.M.9/9/25 at 2 P.M. The DON stated, There's nothing documented under the May [2025] MAR at all.I can't find 9/9 [2025] . The DON stated nursing staff were expected to document on the MAR first to ensure the order is correct. The DON stated nursing staff were to document on the CDR after documenting on the MAR and administering the medication. The DON stated the CDR and MAR documentation should match. The DON stated proper documentation was important to avoid drug diversion and to ensure med errors are not occurring and to make sure efficacy of the medication pre and post [administration]. You can't do that if you don't document on the MAR. A review of the facility's policy and procedure (P&P) titled, Controlled Substances, revised 11/22, indicated, .Handling Controlled Substances.4.an individual.controlled substance record is made for each resident who will be receiving a controlled substance.This record contains.h. date received; i. time of administration. 2. During a concurrent observation and interview on 9/21/25, 10:05 A.M., an inspection of the Medication Room was conducted with Licensed Nurse (LN) 17. Multiple expired medications were observed in the medication refrigerator. a) Four boxes of regular insulin (a diabetes medication used to lower blood sugar) prefilled pens (a newer form of packaging the medication as opposed to the traditional vial) for Resident 7. Two boxes had a manufacturer expiration date of 3/18/25 and the other two boxes had a manufacturer expiration date of 7/1/25. LN 17 confirmed the manufacturer expiration dates. LN 17 stated, that's no good.that's something we must've missed. During an interview with LN 17 on 9/21/25 at 11:31 A.M., LN 17 stated Resident 7's family brought in [the four boxes of insulin] last Friday [9/19/25]. LN 17 stated the risks of expired medications include adverse [negative] effects to the resident if meds are expired.[medications] should be checked prior to administration by nurses.too. During an interview with the DON on 9/22/25 at 1:38 P.M., the DON stated, we don't use [residents'] medications from home, but we store them. The DON stated Resident 7's caregiver.will bring in her.insulin. She's not even on that insulin. The DON stated the facility had nowhere else to store the expired boxes of insulin. The DON stated, we have to keep insulin in the fridge and [there's] no other place to put it aside from the med room. A review of the facility's P&P, titled, Medications Brought to the Facility by the Resident/Family, revised 4/07, indicated, The facility shall ordinarily not permit residents and families to bring medications into the facility. b) Two bottles of compounded (customized preparation of a medication) vancomycin (an antibiotic) eye drops for Resident 29 were labeled with an expiration date of 8/28/25. LN 17 verified the expiration date. During an interview with the DON on 9/22/25 at 1:44 P.M., the DON stated nursing staff were expected to immediately destroy expired medications or remove discontinued medications from the refrigerator. The DON stated this process was important because you don't want to have a medication error by giving a drug [medication] that's expired.A review of the facility's P&P titled, Medication Labeling and Storage, revised 2/23, indicated, .Medication Storage.3. If the facility has discontinued, outdated.medications.the dispensing pharmacy is contacted for instructions regarding returning or destroying these items.

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	055078	A. Building B. Wing	09/24/2025

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. Based on observation, interview, and record review, the facility failed to ensure the medication error rate was less than five percent. The facility's medication error rate was 10.71% when three medication errors occurred out of 28 opportunities during the medication administration for one of seven randomly observed residents (Resident 26). This failure had the potential for Resident 26 not to get the full therapeutic benefit of his medications or to experience negative health outcomes. Findings:During a medication administration observation on 9/21/25 at 9:03 A.M., Licensed Nurse (LN) 1 was observed preparing and administering eleven medications for Resident 26. LN 1 stated Resident 26 received his medications crushed and mixed with applesauce. LN 1 crushed all of Resident 26's tablets individually and mixed each one with applesauce in separate medicine cups, including the following tablet: methadone (a strong painkiller) oral tablet 5 milligrams (mg, unit of measurement) - give 1 tablet by mouth every 8 hours for pain management, dated 9/14/25.LN 1 opened all of Resident 26's capsules (medications that are enclosed in a shell), poured the granules (medicine that is inside capsules) into separate medicine cups and mixed the contents of each medicine cup with applesauce, including the following capsules: duloxetine (a medication used for various psychiatric and neurological conditions) oral capsule Delayed Release (DR, designed to release slowly) Sprinkle 30 mg - give 1 capsule by mouth one time a day for depression (a condition characterized by persistent sadness) AEB (as evidenced by) irritability, dated 9/14/25, and lansoprazole (a medication used to treat heartburn) oral capsule DR 30 mg - give 1 capsule by mouth two times a day for GERD (gastroesophageal reflux disease, acid reflux), dated 9/14/25.During an interview with LN 1 on 9/21/25 at 2:47 P.M., LN 1 verified she opened the duloxetine capsule and mixed the granules with applesauce. LN 1 verified she crushed Resident 26's methadone tablet prior to administration. LN 1 stated lansoprazole was typically given before [a] meal because it's for the stomach. LN 1 confirmed she administered Resident 26's lansoprazole dose in the 9 o'clock hour, which was after breakfast. LN 1 stated breakfast was served around 7:20-7:30 A.M.A review of duloxetine DR capsule drug information, provided by the facility, indicated, Swallow capsule whole; do not crush or chew.A review of the duloxetine DR capsule package insert (PI, document from the drug manufacturer on how to safely and effectively use medications), provided by the facility, indicated, .swallow whole. Do not chew or crush, and do not open the delayed-release capsule and sprinkle its contents on food or mix with liquids because these actions might affect the enteric coating [designed to dissolve in the small intestine instead of the stomach]. A review of methadone tablet drug information, provided by the facility, indicated, Tablets for oral suspension [drug particles in a liquid]: For oral administration only.Do not chew.A review of the methadone PI and medication guide (product labeling information for patients), provided by the facility, indicated, Do not crush, dissolve (the incorporation of a solid into a liquid), snort or inject methadone.tablets because this may cause you to overdose and die.A review of lansoprazole capsule drug information, provided by the facility, indicated, Administer 30-60 minutes before a meal.During a telephone interview with the Consultant Pharmacist (CP) on 9/24/25 at 1:58 P.M., the CP stated duloxetine capsules shouldn't be opened. It should've been given whole. The CP stated that due to the delayed release design, not swallowing it whole can cause increased side effects.reduce[d] effectiveness. Regarding methadone tablets, the CP stated, the manufacturer says you shouldn't crush it because it could lead to.uncontrolled delivery [medication going throughout the body] of methadone. The CP stated, some people crush [methadone] and snort it. They want that extreme high really fast. [Nursing] should not be crushing methadone. When asked about lansoprazole, the CP stated it should be given before breakfast or the first meal [of the day], generally. The CP stated administering lansoprazole that way prevents [stomach] acids from forming. The CP stated he was available to look up meds and tell nurses if a med is crushable or not.A review of the facility's policy and procedure (P&P) titled, Administering Medications, revised 4/2019, indicated, Medications are administered in a safe and timely manner, and as prescribed.

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	055078	A. Building B. Wing	09/24/2025

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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. Based on observation, interview, and record review, the facility failed to ensure a medication was stored under proper temperature controls in one of one Medication Rooms. This failure had the potential to negatively alter the drug's stability, physical properties (such as consistency) and effectiveness, which could result in adverse resident outcomes.Findings:During a concurrent observation and interview on 9/21/25, 10:05 A.M., an inspection of the Medication Room was conducted with Licensed Nurse (LN) 17. A tube of erythromycin (an antibiotic) ophthalmic (for the eye) ointment for Resident 29 was found in the medication refrigerator, which was 37 F (degrees Fahrenheit, a measurement of temperature). The drug manufacturer's labeling on the medication instructed, store between.59 F to 77 F . LN 17 confirmed the manufacturer's labeling and stated, it would have to be stored outside. During an interview with the Director of Nursing (DON) on 9/22/25 at 1:44 P.M., the DON stated medications have to be stored how [the drug manufacturer] says. The DON stated it was important to follow the drug manufacturer's storage instructions because otherwise, improper storage can mess with the medication.During a telephone interview with the Consultant Pharmacist (CP) on 9/24/25 at 1:58 P.M., the CP stated erythromycin ophthalmic ointment should be stored at room temperature. The CP stated, do not freeze [it] because it makes the ointment too thick or hard to apply. Most likely do not refrigerate.A review of erythromycin ophthalmic ointment package insert (document from the drug manufacturer on how to safely and effectively use medications), provided by the facility, indicated, store between.59 F to 77 F.A review of the facility's policy and procedure (P&P) titled, Medication Labeling and Storage, revised 2/2023, indicated, The facility stores all medications.under proper temperature.controls.

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	055078	A. Building B. Wing	09/24/2025

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F 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have a policy regarding use and storage of foods brought to residents by family and other visitors. Based on observation, interview and record review, the facility failed to ensure resident food brought into the facility from outside sources was stored appropriately, and procedures were in place for safe reheating of foods.This failure had the potential to result in pest control concerns, as well as foodborne illnesses.Findings:An observation and interview was conducted on 9/21/25 at 9 A.M. with Resident 24. Resident 24 was sitting in a wheelchair next to her bed. The bedside table was covered with large bags of candy, cookies and other opened food items. A blanket was folded at the foot of the bed, and on top of the blanket was a bunch of ripe bananas and a small brown bag from a fast food restaurant. None of the foods were in plastic bags, and none had labels attached with dates or the resident name and room number. Resident 24 stated the food from the kitchen was sometimes cold, so she had friends and family bring her food from outside to keep in her room. Resident 24 stated the facility had not offered her bins or containers to store her food items. An observation and interview was conducted on 9/24/25 at 12:30 P.M. with Certified Nursing Assistant (CNA) 21. CNA 21 stated if residents wanted to reheat food they had obtained from outside of the facility, the CNA could reheat the food in the microwave. CNA 21 stated she would heat the food for 30 seconds, no matter the food item. CNA 21 stated she did not have instructions for reheating food, and a thermometer was not available to check the temperature of the food. Per CNA 21, she would just heat for 30 seconds then bring the food to the resident to consume. An interview was conducted on 9/24/25 at 12:45 P.M. with CNA 22. CNA 22 stated if residents brought in food from outside, staff should tape a piece of paper on the food item and write the residents' name and room number on it. CNA 22 stated she would also write the date she received the food. An interview with the Registered Dietitian (RD) was conducted on 9/24/25 at 1 P.M. The RD stated instructions for reheating foods should be posted on the resident refrigerator and microwave, and a thermometer should be available to check food temperatures. The RD stated this was important to prevent food related illness, and for food safety. The RD stated she had spoken to Resident 24 and others many times about storing foods safely in the rooms but the residents did not want to let staff touch their belongings. The RD stated there was a risk to the residents from eating spoiled foods, and the facility was responsible for the residents' food safety. An interview was conducted on 9/24/25 at 2 P.M. with the Administrator (Admin). The Admin stated she was not aware foods brought in from home were being reheated without instructions or checking of temperatures. The Admin stated her expectation was for the Dietary Manager (DM) and RD to have established guidance so CNAs could safely reheat foods. The Admin stated she was aware residents stored foods in their rooms, and that this posed a food safety issue and potentially a pest management issue. Per the Admin, no solution had yet been identified. Per a facility policy, dated 2023 and titled Food For Residents From Outside Sources, Food brought in from outside the facility kitchen.will be monitored.Prepared food brought in for the resident must be consumed within one hour of receiving it in an effort to prevent food borne illness. Unused food will be disposed of immediately thereafter.non-perishable foods such as cookies, cake, crackers, fruit, etc. can be stored in the residents room.with the resident's name and date of storage.If opened, the food must be sealed, dated to the date opened and disposed by the best buy date or 30 days, whichever comes first.Per an undated facility policy, titled Foods Brought by Family/Visitors, .All personnel involved in preparing, handling, serving or assisting the resident with meals or snacks will be trained in safe food handling practices.Food brought by family/visitors that is left with the resident to consume later will labeled and stored.Potentially hazardous foods that are left out for the resident without a source of heat or refrigeration longer than 2 hours will be discarded.Per a facility policy, dated 2023 and titled Reheating Food Brought In For A Resident, Resident food brought in from outside the facility will be reheated, if necessary, to 165 degrees for 15 seconds, one time only.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on interview and record review, the facility failed to maintain accurately documented records when the wrong blood pressure (BP) reading was recorded on the Medication Administration Record (MAR, an official legal document that has a complete and accurate record of all medications administered to a resident to ensure patient safety) of one out of five sampled residents (Resident 9). This failure resulted in inaccurate documentation in Resident 9's medical records.Findings:During a concurrent interview and record review with Licensed Nurse (LN) 16 on 9/24/25 at 10:53 A.M., a review of Resident 9's clinical records was conducted. Resident 9's clinical records indicated she had active orders for medications, including the following: losartan (a medication for high blood pressure) 25 milligrams (mg, unit of measurement for dose) - give one tablet by mouth one time a day for HTN (hypertension, high blood pressure). Hold if SBP (systolic blood pressure, the top number in a blood pressure reading) less than 110, started 10/1/24, and metoprolol (a medication for high blood pressure) 25 mg - give one tablet by mouth two times a day (9 A.M. and 9:30 P.M.) for HTN. Hold if SBP less than 110 or HR (heart rate) less than 60 ., started 10/1/24.A review of Resident 9's clinical records indicated her BP was 103/59 on 9/18/25, but received her losartan dose and her 9 A.M. metoprolol dose, despite the blood pressure hold parameter in the physician's orders. LN 16 stated nurses measured BP before administering BP medications. LN 16 stated Certified Nursing Assistants (CNAs) also measured BP throughout the day. LN 16 stated, I accidentally inputted the CNAs vital signs (VS, important measurements such as BP, HR, temperature and respiratory rate [breaths per minute]) rather than the one I took. LN 16 stated he took Resident 9's BP before administering her BP medications on 9/18/25. LN 16 handwrote Resident 9's BP on a sheet of paper on 9/18/25. LN 16 read from that sheet and stated Resident 9's BP was 118/68 on 9/18/25 at 9 A.M.During a concurrent interview and record review of Resident 9's clinical records with the Director of Nursing (DON) on 9/24/25 at 1:13 P.M., the DON stated LN 16 took Resident 9's BP before administering her BP medications at 9 A.M. on 9/18/25 and hand wrote the BP. The DON stated the BP recorded electronically on 9/18/25 was taken by the CNA at 11:25 A.M. The DON stated LN 16 did not enter his own BP reading on Resident 9's MAR on 9/18/25, but entered the CNA's BP reading.A review of the facility's policy and procedure (P&P) titled, Charting and Documentation, revised 7/2017, indicated, .3. Documentation in the medical record will be objective.complete, and accurate.

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	09/24/2025

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, interview and record review, the facility failed to implement proper infection control practices in one of 15 sampled residents (Resident 26). This occurred when Certified Nursing Assistant (CNA) 1 and CNA 2 did not wear proper personal protective equipment (PPE, clothing or equipment, such as gowns, gloves and masks, designed to prevent the spread of infections) while caring for Resident 26, who was on enhanced barrier precautions (EBP, infection control practices designed to prevent the spread of multidrug resistant organisms [MDROs, germs that cannot be killed or inactivated by medications] in nursing homes). This failure had the potential to put residents, staff, and visitors at risk for infections due to cross-contamination.Findings:During a medication administration observation on 9/21/25 at 9:28 A.M., immediately outside Resident 26's room, Licensed Nurse (LN) 1 stated Certified Nursing Assistants (CNAs) were changing Resident 26. LN 1 stated she would give Resident 26 medications after the CNAs were done providing him with care. A sign was observed posted outside Resident 26's door, which read, Enhanced Barrier Precautions [EBP].staff must.wear gloves and a gown for the following high-contact resident care activities.transferring[,] changing linens[,] providing hygiene[,]. CNA 2 and CNA 3 were observed repositioning Resident 26 in a wheelchair. Both CNAs had gloves on, CNA 3 had a mask on, but neither wore a gown. CNA 2 was observed brushing Resident 26's hair and putting a baseball cap on him, while CNA 3 was observed changing linens from Resident 26's bed. CNA 2 was observed without gloves. Resident 26 was observed being transferred out of his room; CNA 2 pushed Resident 26's wheelchair with her bare hands as CNA 3 walked alongside them.During an interview with LN 1 on 9/21/25 at 9:49 A.M., LN 1 stated the EBP sign was for Resident 26 because he has a catheter [a tube used to remove urine from the bladder]. LN 1 stated CNA 2 and CNA 3 should have worn gowns before changing Resident 26's linens and while transferring him. LN 1 stated, they were supposed to gown up.to prevent bacteria from entering him or [CNA 2 and CNA 3] because he has a catheter.During an interview with CNA 2 and CNA 3 on 9/21/25 at 10:01 A.M., CNA 2 stated that because Resident 26 had a catheter, he was on EBP. CNA 2 stated caring for residents on EBP requires staff to gown up usually. That's where we went wrong. CNA 2 stated gowning [wearing gowns] was important to protect ourselves.to protect the patient also.During an interview with the Infection Preventionist (IP) on 9/22/25 at 2:23 P.M., the IP stated staff were expected to wear gloves, gown and a mask when changing linens because there's a chance for things to splash back because there's crumbs and all sorts of things in the bed. The IP stated staff were expected to wear gloves, gown and a mask when transferring a resident on EBP because of the direct contact with the patient. The IP stated PPE was important to wear because without it .infections could.spread throughout the facility.A review of the Centers for Disease Control and Prevention's (CDC, a national agency that provides guidance on public health issues) resource on EBP, titled, Implementation of Personal Protective Equipment (PPE) Use in Nursing Homes to Prevent Spread of Multidrug-resistant Organisms (MDROs), dated 4/2/24, indicated, .PPE .refer to the use of gown and gloves during high-contact resident care activities that provide opportunities for transfer of MDROs to staff hands and clothing. MDROs may be indirectly transferred from resident-to-resident during these high-contact care activities.A review of the facility's policy and procedure (P&P) titled, Enhanced Barrier Precautions, revised 12/2024, indicated, .7. EBPs employ targeted gown and glove use.during high contact resident care activities.c. Face protection may be used if there is a risk of splash or spray. 8. Examples of high-contact resident care activities requiring the use of gown and gloves for EBPs include.c. providing hygiene or grooming.e. transferring.g. changing linens.

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	09/24/2025

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 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** 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.This failure had the potential for residents in rooms 2, 4, 6, and 21 to feel cramped and uncomfortable. 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 sq. ft. per resident.Interviews were conducted with the residents of rooms [ROOM NUMBERS] on 9/23/25 at 11:06 A.M. All residents stated their rooms were comfortable and they had no concerns. Resident room [ROOM NUMBER] accommodated three residents, providing a total of 221 sq. ft. of room, with 73.66 sq. ft. of room space per resident.Interviews were conducted with the residents of Rooms 6 on 9/23/25 at 11:09 A.M. All residents stated their rooms were comfortable and they had no concerns. Resident room [ROOM NUMBER] accommodated four resident occupancy providing a total of 304 sq. ft. per room, with 76 sq. ft. per resident.Interviews were conducted with the residents of Rooms 6 on 9/23/25 at 11:14 A.M. All residents stated their rooms were comfortable and they had no concerns. Variations in room size requirements were not observed to adversely affect the resident's health, safety, quality of care or quality of life during the survey.The Department recommends continuing the room size variance/waiver for Rooms 2, 4, 6 and 21.