

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 465129	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/28/2024
NAME OF PROVIDER OR SUPPLIER Parkway Health Center		STREET ADDRESS, CITY, STATE, ZIP CODE 55 South Professional Way Payson, UT 84651	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44640</p> <p>Based on observation, interview, and record review, for 2 of 42 residents sampled, the facility did not ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source, were reported immediately, but not later than 2 hours after the allegation was made, to the State Survey Agency. Specifically, a resident had a fall while in a mechanical lift and was not reported to the State Survey Agency and a resident had a fall which resulted in a fracture and the State Survey Agency was not notified within 2 hours after the allegation was identified. Resident identifiers: 28 and 156.</p> <p>Findings include:</p> <p>1. Resident 28 was admitted to the facility on [DATE] with diagnoses which included wedge compression fracture of lumbar vertebra, calculus of ureter, bladder neck obstruction, urinary incontinence, fall on same level, weakness, spondylosis, malignant neoplasm of prostate, type II diabetes, atherosclerotic heart disease of native coronary artery.</p> <p>Resident 28's medical record was reviewed 8/25/24 through 8/28/24.</p> <p>On 8/25/24 at 1:45 PM, an interview was conducted with resident 28. Resident 28 stated he had no complaints about the facility but that he had fallen out of the sit to stand because the band around his chest was not tight enough. Resident 28 stated there was only one CNA (certified nursing assistant) helping him when he was using the sit to stand. Resident 28 stated it had happened a few weeks ago.</p> <p>A Physician's Note dated 8/6/24 documented, [Resident 28] he was seen today after having a fall. He had a fall yesterday, using the lift, states he did hit his left shoulder and felt a pop but states today it is not necessarily painful .</p> <p>There was no additional information regarding the incident or an investigation into the incident provided.</p> <p>(continued on next page)</p>		

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 465129
		If continuation sheet Page 1 of 31

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 465129	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/28/2024
NAME OF PROVIDER OR SUPPLIER Parkway Health Center		STREET ADDRESS, CITY, STATE, ZIP CODE 55 South Professional Way Payson, UT 84651	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 8/27/24 at 1:30 PM, an interview was conducted with the Administrator (ADM). The ADM stated he was the abuse coordinator and the staff were to report all suspected abuse or neglect directly to him. The ADM stated they had been working on making this process better and was aware it was lacking. The ADM stated he was unaware of any falls that resident 28 had experienced with the sit to stand. The ADM stated he would look into it.</p> <p>On 8/28/24 at 12:55 PM, an interview was conducted with CNA 1. CNA 1 stated resident 28 needed a mechanical lift to help him stand because his legs were weak. CNA 1 stated resident 28 refused to use the Hoyer lift, which would have been safer. CNA 1 stated resident 28 had fallen out of the sit to stand a few times that he was aware of and 1 time that he had witnessed. CNA 1 stated he did not report the incident because he was just assisting the other worker. CNA 1 stated he was unsure how to report something like that.</p> <p>On 8/28/24 at 2:45 PM, a follow up interview was conducted with the ADM and the Director of Nursing (DON). The DON stated the resident did not fall out of the sit to stand, he just fell to his knees. The DON he was unaware it had happened more than one time. The ADM stated an investigation had not been done for the fall from the sit to stand. The ADM stated this is an ongoing issue the facility was working on.</p> <p>48709</p> <p>2. Resident 156 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included fracture of right femur neck, acute respiratory disease, atrial fibrillation, metabolic encephalopathy, rhabdomyolysis, hypertension, and major depressive disorder.</p> <p>Resident 156's medical record was reviewed on 8/25/24 through 8/28/24.</p> <p>An Event Report Safety Events Fall Event dated 1/10/24 at 9:40 AM indicated resident 156 had an unwitnessed fall in his room. It further indicated, Nursing Description: Patient found on the floor. He fell trying to get his catheter back through his pant leg. Resident Description: He said he fell trying to balance on left leg and thread his Foley through his pant leg and lost balance and landed on his right hip. It further indicated, Injury Type: Other: - unable to move r (right). leg. Location Of Injury: Right Hip. Range of Motion [ROM]: Unable to Complete ROM (If unable- why?) - 10/10 pain right hip. Describe, if necessary. Possible fx [fracture] right hip. X-ray to rule out. It further indicated that the resident was, Sent to ED [emergency department] for evaluation.</p> <p>A Progress Note dated 1/16/24 at 4:03 PM indicated, While at the facility, he had a fall in which he landed on his right hip. He was transported to the hospital for further evaluation. He was found to have a subcapital right hip fracture with mild displacement and rotation of the proximal femur. He was taken to the operating room on one/11/24 [sic] by [physician] for a right hip cemented bipolar hemi arthroplasty .</p> <p>Review of the Form 358: Facility Reported Incidents indicated the Allegation Type, Fall w (with)/fracture. It further indicated administration was notified on 1/10/24 at 5:30 PM. It should be noted that the State Agency received the Form 358 on 1/11/24 at 12:06 PM.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 465129	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/28/2024
NAME OF PROVIDER OR SUPPLIER Parkway Health Center		STREET ADDRESS, CITY, STATE, ZIP CODE 55 South Professional Way Payson, UT 84651	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 8/28/24 at 3:24 PM, an interview was conducted with the DON. The DON stated that any unwitnessed fall should have been investigated for possible neglect. The DON further stated that reporting facility reported events timely was something that they could have done better.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 465129	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/28/2024
NAME OF PROVIDER OR SUPPLIER Parkway Health Center		STREET ADDRESS, CITY, STATE, ZIP CODE 55 South Professional Way Payson, UT 84651	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Respond appropriately to all alleged violations.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48709</p> <p>Based on interview and record review, it was determined, for 5 of 42 sampled residents, that the facility, in response to allegations of abuse, neglect, exploitation, or mistreatment, failed to provide evidence that all alleged violations were thoroughly investigated. Specifically, allegations of neglect resulted in emergency department visits and hospitalizations, two of which resulted with surgical intervention, and one allegation of abuse by a staff member were not thoroughly investigated. Resident identifiers: 15, 53, 156, 158, and 161.</p> <p>Findings include:</p> <p>1. Resident 156 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included fracture of right femur neck, acute respiratory disease, atrial fibrillation, metabolic encephalopathy, rhabdomyolysis, hypertension, and major depressive disorder.</p> <p>Resident 156's medical record was reviewed on 8/25/24 through 8/28/24.</p> <p>An Event Report Safety Events Fall Event dated 1/10/24 at 9:40 AM indicated resident had an unwitnessed fall in his room. It further indicated, Nursing Description Patient found on the floor. He fell trying to get his catheter back through his pant leg. Resident Description He said he fell trying to balance on left leg and thread his Foley through his pant leg and lost balance and landed on his right hip. It further indicated, Injury Type: Other: - unable to move r(right) leg. Location Of Injury Right Hip. Range of Motion [ROM] Unable to Complete ROM (If unable- why?) - 10/10 pain right hip. Describe, if necessary. Possible fx [fracture] right hip. X-ray to rule out. It further indicated that the resident was, Sent to ED [emergency department] for evaluation.</p> <p>A Progress Note dated 1/16/24 at 4:03 PM indicated, While at the facility, he had a fall in which he landed on his right hip. He was transported to the hospital for further evaluation. He was found to have a subcapital right hip fracture with mild displacement and rotation of the proximal femur. He was taken to the operating room on one/11/24 [sic] by [physician name] for a right hip cemented bipolar hemi arthroplasty .</p> <p>On 8/28/24 at 3:24 PM, an interview was conducted with the Director of Nursing (DON). The DON stated that any unwitnessed fall should have been investigated for possible neglect.</p> <p>On 8/28/24 at 4:42 PM, an email was provided by the Administrator (ADM). Exhibit 359 was attached. The email indicated, .Not knowing the case number prevented the completion of the 359. No other documentation was provided regarding an investigation.</p> <p>43212</p> <p>2. Resident 158 was admitted on [DATE] and was readmitted on [DATE] with diagnoses that included acute respiratory distress syndrome, pulmonary embolism, sepsis, laceration without foreign body, lower left leg, and polyneuropathy.</p> <p>Resident 158's medical record was reviewed between 8/25/24 and 8/28/24.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 465129	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/28/2024
NAME OF PROVIDER OR SUPPLIER Parkway Health Center		STREET ADDRESS, CITY, STATE, ZIP CODE 55 South Professional Way Payson, UT 84651	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>An entity 358 revealed that on 9/5/23 at 12:19 PM, resident 158 sustained a laceration to his shin from an unknown origin. The resident was assessed and a pressure bandage was applied. Resident 158 was transported via EMS (emergency medical services) to the hospital. The 358 entity report revealed resident 158 appeared to be shaking, pale, and had pinpoint pupils. Police were notified.</p> <p>An entity 359 was received on 9/12/23 at 11:45 AM, and revealed resident 158 had cut his leg on the side of his bed while using a power wheel chair. The 359 report stated, Injury was of known source from scraping against the bed frame. The investigation portion of the 359 report revealed, Interviews were done with staff working that hall. The summary of the interviews included, Nurse assisted resident who was stuck against the bed by the night stand. She applied pressure and called ems. The other interview summaries contained N/A [not applicable]. The conclusion included, Not verified this was injury of known source.</p> <p>It should be noted that no additional investigation documents were provided that included interviews, evaluations or education that was provided after the incident. It should also be noted that the 359 entity report was submitted after 7 days.</p> <p>44640</p> <p>3. Resident 15 was admitted to the facility on [DATE] with diagnoses which included myasthenia gravis, pain, essential hypertension, opiod use, acute kidney failure, seizures, herpesviral vulvovaginitis, muscle spasm, constipation, anxiety disorder, hypothyroidism, edema, muscle weakness, major depressive disorder, and major depressive disorder.</p> <p>Resident 15's medical record was reviewed 8/25/24 through 8/28/24.</p> <p>The exhibit 358 revealed that staff became aware of the incident on 8/24/23 at an 3:00 PM. The exhibit revealed that resident 15 alleged, The CNA did not deliver meals, not answer call lights, and left the resident. Immediate action to protect resident was documented as, Alleged perpetrator was immediately asked to leave facility on leave until investigation is completed.</p> <p>Exhibit 359 was not located in the abuse log provided by the facility.</p> <p>For the allegation no investigation was provided by the facility.</p> <p>On 8/26/24 at 9:41 AM, an interview was conducted with resident 15. Resident 15 stated the incident did take place but she could not remember all the details since it happened so long ago. Resident 15 stated there was a lot of neglect that went on in the facility back then. Resident 15 stated the facility had gotten better with the new management team and if she had problems she would let the administration know. Resident 15 stated that they take good care of her.</p> <p>On 8/27/24 at 2:25 PM, an interview was conducted with the ADM. The ADM stated the incident with resident 15 occurred before his time at the facility and he was unable to find an investigation or 359 for the incident.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 465129	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/28/2024
NAME OF PROVIDER OR SUPPLIER Parkway Health Center		STREET ADDRESS, CITY, STATE, ZIP CODE 55 South Professional Way Payson, UT 84651	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>4. Resident 53 was admitted to the facility on [DATE] with diagnoses which included atherosclerotic heart disease of native coronary artery, fracture of superior rim of right pubis, wedge compression fracture of T(thoracic)11-T12 vertebra, fall on same level, chronic viral hepatitis C, altered mental status, hepatic failure, weakness, anxiety disorder type II diabetes and hyperlipidemia.</p> <p>Resident 53's medical record was reviewed 8/25/24 through 8/28/24.</p> <p>The exhibit 358 revealed that staff became aware of the incident on 8/1/24 at 4:30 PM. The exhibit revealed that resident 11 alleged, Staff responded to [resident 53's] room to find pt. (patient) on the mat again with further injury. and Immediate action to protect resident was documented as, [Resident 53] was sent to hospital again for further evaluation in the day with arm in sling and information indicated of a potential ' current or former ' injury.</p> <p>The exhibit 359 revealed that Determined that [resident 53's] fall was an unfortunate event and while staff checked on her frequently, she became mobile and appeared to have fallen while in a state of confusion. A summary on interviews with alleged perpetrator revealed, Staff indicated that resident received frequent checks and appeared at current baseline. And no concerns noted. A summary of information from the investigation revealed, n/a. The allegation was not verified and marked as inconclusive, Determined that [resident 53's] fall was an unfortunate event and while staff checked on her frequently, she became mobile and appeared to have fallen while in a state of confusion.</p> <p>Progress notes dated 8/1/24 revealed, Patient was found on floor by CNA. CNA went in to check on patient and found patient on the floor in extreme pain. CNA ran to get nurse to assess patient. Upon assessment Nurse noticed that left arm was limp and looked to be dislocated. Nurse looked for any other injuries and no other injuries were noted. Patient was helped back into bed and vitals taken. Nurse notified family and Hospice of the fall, family did not want patient to get sent out to the hospital since patient was on hospice. Nurse gave patient PRN morphine to help with the pain. Hospice nurse is coming to evaluate patient.</p> <p>For the allegation no investigation was provided by the facility</p> <p>5. Resident 161 was admitted to the facility on [DATE] with diagnoses which included osteomyelitis, pressure ulcer of sacral region, stage 4, enterocolitis due to Clostridium difficile, paraplegia, autoimmune hepatitis, cirrhosis of liver, acute metabolic acidosis, bradycardia, bacteremia, thrombocytopenia, pain, disorder of kidney and ureter, neuromuscular dysfunction of bladder, obstructive sleep apnea, hypertension, and gastro-esophageal reflux disease.</p> <p>Resident 161's medical record was reviewed 8/25/24 through 8/28/24.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 465129	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/28/2024
NAME OF PROVIDER OR SUPPLIER Parkway Health Center		STREET ADDRESS, CITY, STATE, ZIP CODE 55 South Professional Way Payson, UT 84651	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>The exhibit 358 revealed that staff became aware of the incident on 3/22/24 at 3:00 PM. The exhibit revealed that the local hospital staff alleged, Adult Protective Services (APS) contacted the Resident Advocate (RA) to inquire further regarding a case called in to their office. RA alerted the facility Administrator of the report. The administrator and staff investigated the incident further to determine that [local hospital] staff contacted APS with an allegation of neglect for [resident 161]. The claim alleges that [resident 161] was sent to [local hospital] following concerns with heart-rate and respiratory issues. [Resident 161] had been at [facility] for a couple of months for variety of care needs. [Local hospital] Emergency Department alleges that [resident 161] arrived and presented disheveled and rough appearance. Upon being contacted from APS and further contact with [local hospital], it was determined than an allegation was made and the facility is now reporting the alleged event per the facility's reporting steps and measures. Immediate action to protect resident was documented as, Resident [161] was admitted to [local hospital] for further cares. Resident was transferred to [specialty hospital] for further treatment with plans to return to [facility] and Rehabilitation following his stay there. The facility will continue its investigation process and review to</p> <p>determine the details of the allegation, review the findings, make any necessary recommendations or changes, report to the facility's QAPI [Quality Assurance and Performance Improvement] Committee for analysis and necessary action steps.</p> <p>The exhibit 359 revealed that on 3/14/24 at an unknown time, [Resident 161] was interviewed following his transfer to [local hospital]. He reported that he did not remember much about the transfer and admission to the ER [emergency room] and [local hospital] and indicated he was told afterwards about the details and transfer. A summary on interviews of the staff revealed, Interview Wound Nurse (WN) and the DON regarding the event and they provided further information regarding attempts made to send [resident 161] to the hospital that he denied, but did admit to the hospital for the low O2 [oxygen] levels and explained that the there may have been a leak in his colostomy and. may have caused further alarm and issues upon review. The allegation was not verified, [Facility] continues to work and improve our clinical care practices, systems, and review processes. While there is a lot to learn from this situation and additional review and corrective actions have been reported to the operations QAPI committee for further evaluation, implementation of corrective actions, and necessary review and oversight processes.</p> <p>On 8/27/24 at 11:25 AM, an interview was conducted with the ADM. The ADM stated there was no other investigative notes for the incidents. The ADM stated they had talked to the staff involved with resident 53 and 161 but did not have the documentation. The ADM stating improving this process was part of the QAPI plan that was in place. The ADM stated they started the new process in April of this year and they were still working on it. The ADM stated he was the abuse coordinator and it was his responsibility to ensure the investigations were completed appropriately.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 465129	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/28/2024
NAME OF PROVIDER OR SUPPLIER Parkway Health Center		STREET ADDRESS, CITY, STATE, ZIP CODE 55 South Professional Way Payson, UT 84651	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0697</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe, appropriate pain management for a resident who requires such services.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44640</p> <p>Based on observation, interview, and record review, the facility did not ensure that pain management was provided to residents who required such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals preferences. Specifically, for 1 out of 42 sampled residents, a resident was observed to complain about pain and pain medications were not available. Resident identifier: 16.</p> <p>Findings include:</p> <p>Resident 16 was admitted to the facility on [DATE] with diagnoses which included type II diabetes mellitus, protein calorie malnutrition, morbid obesity with alveolar hypoventilation, vascular dementia, mood disorder, opioid dependence, anxiety disorder, obstructive sleep apnea, Bell's palsy, chronic pain, muscle weakness, unsteadiness on feet and lack of coordination.</p> <p>On 8/27/24 at 8:09 AM, an observation was made of Registered Nurse (RN) 3 during morning medication pass. RN 3 stated it now looked like resident 16 had 2 Fentanyl patches and that they had decreased his dose and stated that he would not like that. RN 3 was observed to call over his ADON (Assistant Director of Nursing) to assist. The ADON was observed to look over the order and stated that is the new order for resident 16 and she did not know why it had changed but thought there was something to do with insurance.</p> <p>On 8/27/24 at 8:15 AM, an observation was made as resident 16 received his morning medications. Resident 16 was observed to ask RN 3, Do you have my Fentanyl patch because it has been out for a week and I have been hurting? RN 3 informed resident 16 he did have his Fentanyl patch but it was now 2 patches instead of just one because the dosage had changed. Resident 16 stated, They told me it was because if my insurance? RN 3 was observed to put the 2 Fentanyl patches on the upper left side of resident 16's back and tell resident 16 he would check into it.</p> <p>Resident 16's medical record was reviewed 8/25/24 through 8/28/24.</p> <p>A care plan dated 6/28/24 revealed, [Resident 16] has pain. [Resident 16] is at risk for pain secondary to poor bed mobility. The goal was [Resident 16] will have no unaddressed pain, through next review. The intervention included Offer non-pharmacological approaches to pain management [massage ice, reposition, etc.]. Monitor for side effects of pharmacological pain interventions and notify physician with positive signs or symptoms of side effects. Medications as prescribed. Monitor pain as prescribed.</p> <p>The physician's order dated 8/10/24, revealed Fentanyl patch 72 hour; 37.5 mcg (microgram)/hr (hour); amt (amount) 1 patch; quantity: 10; transdermal. Special instructions: Apply 1 patch every 72 hrs (hours). Once a day every 3 day. With a start date of 8/10/24 and an end date of 8/19/24.</p> <p>The same physician order for the Fentanyl 37.5 mcg was started on 8/19/24 and dc' d (discontinued) on 8/19/24 the restarted on 8/19/24 and dc' d on 8/20/24.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 465129	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/28/2024
NAME OF PROVIDER OR SUPPLIER Parkway Health Center		STREET ADDRESS, CITY, STATE, ZIP CODE 55 South Professional Way Payson, UT 84651	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0697</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The physician's order dated 8/20/24, revealed Fentanyl patch 72 hour; 25 mcg/hr; amt 1; quantity: 10; transdermal. Special instructions: Apply 1 patch every 72 hrs. Apply on the same day/time as the 12 mcg patch.</p> <p>A physician progress note revealed on 8/6/24, He has chronic low back pain that is currently being treated with fentanyl 37.5 mg patches and Gabapentin 600 mg (milligram) Q (every)6 hrs. He was on Percocet QID (four times a day) for many years but felt that it was no longer effective. He was switched to Fentanyl patches about a month ago. He is unable to determine the efficacy d/t (due to) new patches being late by a day each time. APC (Advanced Provider of Care) spoke with RN about the reason for patches not being changed on time, and we may have fixed the MAR (Medical Administration Record) issue.</p> <p>The August MAR revealed on 8/21/24, 8/22/24, 8/23/24, 8/24/24, 8/25/24, and 8/26/24 Fentanyl patch 72 hour; 12 mcg/hr was not administered: drug/item unavailable.</p> <p>The August MAR revealed on 8/21/24 and 8/22/24 Fentanyl patch 72 hour; 25 mcg/hr was not administered: drug/item unavailable. On 8/23/24 and 8/24/24 Fentanyl patch 72 hour; 25 mcg/hr was not administered: other comment: waiting to get 12 mcg patch. On 8/25/24 and 8/26/24 Fentanyl patch 72 hour; 25 mcg/hr was not administered: on hold comment: Will apply when the 12 mcg patch is available.</p> <p>On 8/27/24 at 8:25 AM, an interview was conducted with RN 3. RN 3 stated he was unsure why the resident was changed from the 37.5 mcg Fentanyl patch to the 2 other patches that equal 37 mcg. RN 3 was observed to look at the August MAR with this surveyor and was unable to determine why the resident had not received his patches from 8/20/24 through 8/26/24. RN 3 stated the process for getting medications that were needed was to call the pharmacy and they would deliver them. RN 3 stated the pharmacy came to the facility multiple times a day to deliver needed medications. RN 3 stated they did keep a supply of medications in a locked machine in the medication room but he was unsure if Fentanyl patches were in that supply.</p> <p>The pain history for resident 16 was reviewed and revealed, on a number pain scale from 0-10, with number 0 being no pain and number 10 being extreme pain, that resident 16's pain ranged from 2 to 10. No significant increased in pain was noted in the medical record for resident 16 during the time frame the Fentanyl patches were not available.</p> <p>On 8/27/24 at 11:17 AM, an interview was conducted with the Director of Nursing (DON). The DON stated there was an issue with resident 16's Fentanyl patch and his insurance. The DON stated the pharmacy could no longer get the original dose of 37.5 mcg so the provider was in agreeance to change the order to 37.0 mcg. The medication did not come so the nurses kept ordering it but the pharmacy thought they had already sent it, so they did not send a new supply. The DON stated the resident did not have increased pain during the time the Fentanyl patches were not available because the provider had changed resident 16's opioid to scheduled and changed another medication. The DON stated no one checked with the pharmacy to determine what was going on with the medication. The DON stated it was a process that needed correction. And that it was ultimately the responsibility of the facility to ensure each resident got the medications that they needed.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 465129	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/28/2024
NAME OF PROVIDER OR SUPPLIER Parkway Health Center		STREET ADDRESS, CITY, STATE, ZIP CODE 55 South Professional Way Payson, UT 84651	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44640</p> <p>Based on interview and record review it was determined, for 1 of 42 sampled residents, that the facility did not provide routine and emergency drugs and biological's to its residents. Specifically, a resident was not administered medications as ordered by the physician due to the medications not being available by the pharmacy. Resident identifier: 16</p> <p>Findings Included:</p> <p>Resident 16 was admitted to the facility on [DATE] with diagnoses which included type II diabetes mellitus, protein calorie malnutrition, morbid obesity with alveolar hypoventilation, vascular dementia, mood disorder, opioid dependence, anxiety disorder, obstructive sleep apnea, Bell's palsy, chronic pain, muscle weakness, unsteadiness on feet and lack of coordination.</p> <p>On 8/27/24 at 8:15 AM, an observation was made as resident 16 received his morning medications. Resident 16 was observed to ask RN (Registered Nurse) 3, Do you have my fentanyl patch because it has been out for a week? RN 3 informed resident 16 he did have his fentanyl patch but it was now 2 patches instead of just one because the dosage had changed. Resident 16 stated, They told me it was because if my insurance? RN 3 was observed to put the 2 fentanyl patches on the upper left side of resident 16's back and tell resident 16 he would check into it.</p> <p>Resident 16's medical record was reviewed 8/25/24 through 8/28/24.</p> <p>On 8/21/24, an order administration note documented, Fentanyl patch 72 hour; 25 mcg [microgram]/hr [hour] . Administer: 1 patch transdermal. Not Administered: Drug/Item Unavailable.</p> <p>On 8/22/24, an order administration note documented, Fentanyl patch 72 hour; 25 mcg/hr . Administer: 1 patch transdermal. Not Administered: Drug/Item Unavailable.</p> <p>On 8/23/24, an order administration note documented, Fentanyl patch 72 hour; 25 mcg/hr . Administer: 1 patch transdermal. Not Administered: Other Comment: Waiting to get the 12 mcg patch.</p> <p>On 8/24/24, an order administration note documented, Fentanyl patch 72 hour; 25 mcg/hr . Administer: 1 patch transdermal. Not Administered: Other Comment: Waiting to get the 12 mcg patch.</p> <p>On 8/25/24, an order administration note documented, Fentanyl patch 72 hour; 25 mcg/hr . Administer: 1 patch transdermal. Not Administered: Other Comment: Waiting for the 12 mcg patch to use together.</p> <p>On 8/26/24, an order administration note documented, Fentanyl patch 72 hour; 25 mcg/hr . Administer: 1 patch transdermal. Not Administered: On Hold Comment: Waiting for the 12 mcg patch to use together.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 465129	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/28/2024
NAME OF PROVIDER OR SUPPLIER Parkway Health Center		STREET ADDRESS, CITY, STATE, ZIP CODE 55 South Professional Way Payson, UT 84651	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 8/27/24 at 8:25 AM, an interview was conducted with RN 3. RN 3 stated he was unsure why the resident was changed from the 37.5 mcg Fentanyl patch to the 2 other patches that equaled 37 mcg. RN 3 was observed to look at the August MAR (Medication Administration Record) with this surveyor and was unable to determine why the resident had not received his patches from 8/20/24 through 8/26/24. RN 3 stated the process for getting medications that were needed was to call the pharmacy and they would deliver them. RN 3 stated the pharmacy came to the facility multiple times a day to deliver needed medications. RN 3 stated they did keep a supply of medications in a locked machine in the medication room but he was unsure if Fentanyl patches were in that supply.</p> <p>On 8/28/24 at 1:16 PM, an interview was conducted with the Director of Nursing (DON). The DON stated there was a error with the pharmacy and that was the reason resident 16 had not received his medication. The DON stated resident 16 was originally getting 37.5 mcg of Fentanyl and then the pharmacy stated they could no longer provide that dose but could provide 37.0 mcg in 2 separate patches, so the provider changed the order to equal this amount. The DON stated the pharmacy had not sent the medication, and the nurses kept ordering it so the pharmacy thought they had already sent it. But no one was checking to see where the medication actually was. The DON stated the nurses had one of the Fentanyl patches, either the 25 mcg or the 12 mcg the DON was unsure, but the nurses were waiting to have both of them before they administered anything to the resident. The DON stated the resident should not have gone without his pain medication and that he was aware the process needed some clarification and follow through to ensure the residents did not go without the medications they needed.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 465129	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/28/2024
NAME OF PROVIDER OR SUPPLIER Parkway Health Center		STREET ADDRESS, CITY, STATE, ZIP CODE 55 South Professional Way Payson, UT 84651	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p>44640</p> <p>Based on observation and interview it was determined that the facility did not label all drugs and biological's used in the facility in accordance with currently accepted professional principles, and include appropriate accessory instructions and the expiration date when applicable. Specifically, medication carts were left unlocked and unattended, insulin pens were open and available for use past the expiration date. In addition, narcotics were repackaged into the narcotic cards.</p> <p>Resident Identifiers: 4, 5, 15, 21, 23, 34, 38, 39 and 48.</p> <p>Findings included:</p> <p>During morning medication pass the following was observed:</p> <p>1. On 8/27/24 at 7:45 AM, an observation was made of the 300 hallway. Registered Nurse (RN) 2 was observed with a medication cart. RN 2 was observed to walk away from the unlocked medication cart and enter a resident's room. The medication cart was observed to be unlocked, have a drawer open and the computer screen was open to a resident's identifying information. Two residents were observed to be in the dayroom and within viewing distance of the medication cart computer.</p> <p>2. On 8/27/24 at 8:00 AM, an observation was made of the 300 hallway. RN 2 was observed to leave the unlocked medication cart unattended and the computer screen was open with resident's identifying information in view of other residents.</p> <p>3. On 8/27/24 at 8:10 AM, an observation was made of the 100 hallway. RN 3 was observed to leave the medication cart unlocked and go into the medication storage room.</p> <p>4. On 8/27/24 at 7:15 AM, an observation was made of the 400 hallway medication cart with Registered Nurse (RN) 1, the following medications were located inside:</p> <p>a. A pre-filled pen of Lispro Injection Kwikpen 100 unit/ml (milliliters). Medication was opened and available for use and labeled with an open date of 7/26/24 and resident 48's name.</p> <p>b. A pre-filled pen of Admelog Injection 100 unit/ml. Medication was opened and available for use and labeled with an open date of 7/26/24 and resident 5's name.</p> <p>5. On 8/27/24 at 7:45 AM, an observation was made of the 300 hallway medication cart with Registered Nurse (RN) 2, the following medications were located inside:</p> <p>c. A pre-filled pen of Lispro Injection Kwikpen 100 unit/ml. Medication was opened and available for use and labeled with an open date of 7/26/24 and resident 34's name.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 465129	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/28/2024
NAME OF PROVIDER OR SUPPLIER Parkway Health Center		STREET ADDRESS, CITY, STATE, ZIP CODE 55 South Professional Way Payson, UT 84651	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 8/27/24 at 7:30 AM, an interview was conducted with RN 1. RN 1 stated she was unsure how long insulin was good for after it was opened. RN 1 stated when a new insulin pen was removed from the fridge the residents name should be on the pen and an open date was written on the pen. RN 1 stated the insulin's in the medication cart for the 400 hallway were the ones that they were currently using for the residents.</p> <p>On 8/27/24 at 7:50 AM, an interview was conducted with RN 2. RN 2 stated insulin was good for 30 days. RN 2 stated the insulin's in the medication cart for the 300 hallway were the insulin's that were currently being used for the residents.</p> <p>6. On 8/27/24 at 7:18 AM, an observation was made of the 400 hallway medication cart with RN 1, the following medications were located inside:</p> <p>d. A medication card which held Oxycodone 10 mg (milligram) for resident 4 had the back of pocket number 27, 36 and 37 taped, no medication was located inside the pockets.</p> <p>e. A medication card which held Tramadol 50 mg for resident 38 had the back of pocket number 18 taped, a white tablet was observed to be taped into the pocket.</p> <p>7. On 8/27/24 at 8:25 AM, an observation was made of the 100 and 200 hallways medication cart with RN 3, the following medications were located inside:</p> <p>f. A medication card which held Clonazepam 1 mg for resident 15 had the back of pocket number 5, 8, 11, 17, and 22 taped; a tablet was observed to be taped into pocket number 5 the other pockets were observed to have no medications in them.</p> <p>g. A medication card which held Tramadol 50 mg for resident 15 had the back of pocket number 15, 16, 17, 18, 19, 41 and 50 taped; 2 white tablets were observed to be taped into pocket number 15 and 1 white tablet was observed to be taped into pocket 16. The other taped pockets were observed to have no medications in them.</p> <p>h. A medication card which held Gabapentin 100 mg for resident 23 had the back of pocket number 39 taped; 1 capsule was observed to be taped into pocket number 39.</p> <p>i. A medication card which held Pregamblin 200 mg for resident 21 had the back of pocket number 9 taped, a medication was observed to be in pocket number 9.</p> <p>j. A medication card which held Temasepam 30 mg for resident 39 had the back of pocket number 15 taped with a Band-Aid, a medication was observed to be in the pocket.</p> <p>On 8/27/24 at 7:30 AM, an interview was conducted with RN 1. RN 1 stated narcotics should not be retaped into the narcotic cards. RN 1 stated it makes it difficult to see what medication is in the card and the nurse would not know if the correct medication had been put back into the card.</p> <p>On 8/27/4 at 7:56 AM, an interview was conducted with RN 2. RN 2 stated that is was fine to retape medications and narcotics back into the cards if they were not dirty, if the nurse knew what the medication was and if a resident refused the medication.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 465129	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/28/2024
NAME OF PROVIDER OR SUPPLIER Parkway Health Center		STREET ADDRESS, CITY, STATE, ZIP CODE 55 South Professional Way Payson, UT 84651	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 8/27/24 at 8:35 AM, an interview was conducted with RN 3. RN 3 stated that is was never appropriate to retape medications back into the medication cards. RN 3 stated, There was so much wrong with that! RN 3 stated the resident could get the wrong medication or the wrong dose. RN 3 stated you just would have no way of knowing what the medication was that was put back into the card.</p> <p>On 8/27/24 at 10:00 AM, an interview was conducted with the Director of Nursing (DON). The DON stated insulin was good for 28 days. The DON stated the insulin in the drawers should have been discarded after the 28 days. The DON stated the staff were supposed to label and date all insulin before they were put into the medication carts. The DON stated the nurses were expected to lock the computers and medication carts if they left them. The DON stated it was unsafe to leave the medication carts unlocked and computer screens were locked to ensure resident privacy. The DON stated the nurses were supposed to waste narcotics with another nurse and never retape a medication back into a medication card, they were supposed to waste or destroy the medication.</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 465129	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/28/2024
NAME OF PROVIDER OR SUPPLIER Parkway Health Center		STREET ADDRESS, CITY, STATE, ZIP CODE 55 South Professional Way Payson, UT 84651	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0801</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p>43212</p> <p>Based on interview, the facility did not employ a clinically qualified full-time dietitian or another clinically qualified nutrition professional to serve as the director of nutrition services. Specifically, the facility did not employ a full time Registered Dietitian (RD) and the Dietary Manager (DM) did not meet the requirements to serve as the Director of Nutrition Services.</p> <p>Findings include:</p> <p>On 8/26/24 at 8:40 AM, an interview was conducted with the DM who stated she had not completed the required certification to work as the dietary manager. The DM stated the RD came to the facility on ce per week on Thursday, and if she had questions she could call the RD at any time.</p> <p>On 8/28/24 at 12:17 PM, an interview was conducted with the RD who stated the DM was still going through the training plan, and that she had just started in the position 2-3 weeks ago. The RD confirmed that the DM did not have the required certification yet. The RD stated the goal was to provide DM with a list of who offered approved training. The RD stated the DM could call her any time if she had questions or concerns.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 465129	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/28/2024
NAME OF PROVIDER OR SUPPLIER Parkway Health Center		STREET ADDRESS, CITY, STATE, ZIP CODE 55 South Professional Way Payson, UT 84651	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0803</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44640</p> <p>Based on observation, interview and record review, for 4 of 42 sampled residents, the facility did not have menus that met the nutrition needs of residents in accordance with established nutrition guidelines. In addition, the menus were not followed. Specifically, residents complained about the portion sizes being too small. Resident identifiers: 8, 12, 34, and 167.</p> <p>Findings include:</p> <p>On 8/25/24 at 12:00 PM lunch service was observed on the 100 and 200 hallways and the following was observed:</p> <p>Resident 8 was observed to be sitting in the dining room eating his lunch. A piece of chicken was observed to be on resident 8's plate. The chicken was observed to be the size of a silver dollar. Resident 8 stated the amount of chicken was small and he would have liked it to be bigger.</p> <p>Resident 12 was observed to be in bed with his bedside table in front of him. Resident 12 was observed to have a piece of chicken on his plate that was the size of silver dollar. Resident 12 stated the food was no good, and the meat was too small.</p> <p>Resident 167 was observed to be sitting in bed with his bedside table in front of him. Resident 12 was observed to be holding a knife and fork and attempted to cut the piece of chicken. Resident 12 said he could cut it but stated the piece was small.</p> <p>43212</p> <p>Resident 34 was admitted on initially on 6/3/21 and readmitted on [DATE] with diagnoses that included cerebral palsy, diabetes mellitus, hyponatremia, malnutrition and depression.</p> <p>On 8/25/24 at 2:53 PM, an interview was conducted with resident 34 who stated the meals received the day before were garbage. Resident 34 stated the lunch meal on the day before were broccoli and rice casserole for lunch and beef stroganoff for dinner that consisted of noodles with watery brown gravy and very little meat. Resident 34 stated the cook apologized for the meal yesterday evening and provided doughnuts to the residents to make up for it.</p> <p>The Daily Spreadsheet was reviewed prior to the lunch meal. The meal consisted of pork medallions, herbed buttered pasta, broccoli florets, a dinner roll with butter, choice of beverage, and a piece of pumpkin cake with cream cheese frosting. Portion sizes were as follows:</p> <p>a. Pork Medallions: Regular portion was 3 oz (ounces) of meat with 1 oz of gravy; large portion was 4 oz of meat with 1 oz of gravy; small portion was 2 oz of meat with 1 oz of gravy. Mechanical soft (3 and 2) was a # (number) 8 scoop (1/2 cup) of ground meat with 1 oz and 2 oz of gravy respectively.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 465129	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/28/2024
NAME OF PROVIDER OR SUPPLIER Parkway Health Center		STREET ADDRESS, CITY, STATE, ZIP CODE 55 South Professional Way Payson, UT 84651	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0803</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>b. Herbed buttered pasta: Regular portion was a #8 scoop of pasta; large portion was #6 scoop (2/3 cup); small portion was a #16 scoop (1/4 cup); Mechanical soft 3 was a #8 scoop of pasta; Mechanical soft 2 was to receive soft and chopped pasta with 2 oz of gravy or sauce of choice.</p> <p>c. Broccoli florets: Regular portion was #8 scoop of broccoli; Large portion was #6 scoop of broccoli; Small portion was a #12 scoop (1/3 cup) of broccoli; Mechanical soft 3 was a #8 scoop of broccoli, soft and chopped into smaller pieces; Mechanical soft 2 was #12 scoop of broccoli pureed.</p> <p>d. Dinner roll with butter: Regular portion was 1 roll with 1 serving of butter; Large portion was 2 rolls with 2 servings of butter; Small portion was 1 roll with 1 serving of butter; Mechanical soft 3 was a soft roll with 1 serving of butter; Mechanical 2 was #16 scoop of pureed roll.</p> <p>e. Choice of beverage: Regular, large, small, and mechanical 3 and 2 diet were to receive 1 cup.</p> <p>f. Pumpkin cake with cream cheese frosting: Regular, large, small and mechanical 3 and 2 diets were to receive a 3 x 2 inch piece.</p> <p>On 8/27/24 at 11:50 AM, an observation was made of the tray line. The cook (CK) 1 was interviewed and stated she was using a #8 scoop for the noodles, a 1oz ladle for the gravy, a #10 scoop for the chopped meat, and a #8 scoop for the broccoli. The pork medallions were roughly 3 x 2.5 inches and 1/2 inch thick. During tray line, Dietary Aide (DA) 2 was observed to call out the diet order and CK 1 plated the meal. For a regular portion, the resident received 1 piece of meat with 1 oz of gravy, 1 #8 scoop of pasta, 1 #8 scoop of broccoli florets, 1 dinner roll with 1 serving of butter, and a 3 x 2 piece of cake. For a large portion meal, the resident received 2 pieces of meat with 1 oz of gravy, 1 #8 scoop of pasta, 1 #8 scoop of broccoli florets, 1 dinner roll with 1 serving of butter and a 3 x 2 piece of cake. No small portions were observed to be served. For the mechanical 3 meal, residents received a #10 scoop (3/8 cup) of ground meat with 1 oz of gravy, a #8 scoop of chopped broccoli, and 1 dinner roll with a serving of butter and a 3 x 2 piece of cake. No puree meals were observed to be served.</p> <p>It should be noted that the portion size of the meat did not appear to be 3 oz. It should so be noted that for residents that disliked green vegetables or broccoli, steamed carrot cubes were served.</p> <p>On 8/28/24 at 12:17 PM, an interview was conducted with the Registered Dietitian (RD) who stated she conducted food quality audits on a weekly basis when she was in the building. The RD stated she did not know if she had a record of the test trays.</p> <p>On 8/28/24 at 1:52 PM an interview was conducted with the Dietary Manager (DM) who stated that one of the cooks needed a lot more training, and especially with food presentation, following the menus and spreadsheets. The DM stated she had complaints from residents about the portion sizes of the food.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 465129	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/28/2024
NAME OF PROVIDER OR SUPPLIER Parkway Health Center		STREET ADDRESS, CITY, STATE, ZIP CODE 55 South Professional Way Payson, UT 84651	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44640</p> <p>Based on observation, interview and record review, the facility did not provide food prepared by methods that conserve flavor and appearance or provide food and drink that is palatable, attractive, and at an appetizing temperature. Specifically, there were multiple complaints from residents about the quality of the food, and when surveyors pulled a test tray during the lunch meal, the food was found to be lacking in flavor and appearance. Resident identifiers: 4, 8, 9, 12, 19, 29, 30, 32, 34, 36, 39, 45, 166 and 206.</p> <p>Findings include:</p> <p>On 8/25/24 at 11:19 AM, an interview was conducted with resident 8. Resident 8 stated he did not like the food and that he wouldn't feed this food to his dogs.</p> <p>On 8/25/24 at 11:25 AM, an interview was conducted with resident 166. Resident 166 stated the food was usually cold when it was brought to her and that it did not taste very good.</p> <p>On 8/25/24 at 11:47 AM, an interview was conducted with family member (FM) of resident 19. FM stated the food was not good, the portions were for children and they did not give them what they asked for.</p> <p>On 8/25/24 at 11:52 AM, an interview was conducted with resident 12. Resident 12 stated the food was usually cold then it got to him. Resident 12 stated the food was worse than prison food.</p> <p>On 8/25/24 at 12:03 PM, an interview was conducted with resident 39. Resident 39 stated the food was inedible and that they got a new kitchen person and it was just bad. Resident 39 stated she was not sure she had ever tasted food so bad.</p> <p>48709</p> <p>On 8/25/24 at 11:32 AM, an interview was conducted with resident 4. Resident 4 stated the dinner last night was nasty and that he could not even tell what the food was.</p> <p>On 8/25/24 at 12:21 PM, an interview was conducted with resident 206. Resident 206 stated he was served 2 slices of untoasted bread with gravy on it and it was supposed to be biscuits and gravy. Resident 206 stated, It was bad.</p> <p>On 8/25/24 at 1:14 PM, an observation was made of the Resident Advocate (RA). The RA brought donuts out to three residents who were sitting outside in the smoking area. The RA told the residents that the new dietary manager heard how bad the food was yesterday so she had gotten the residents donuts to let them know that she was aware. An interview with resident 36 was conducted after the RA went back inside the facility. Resident 36 stated they brought them [NAME] Taco one day for the same reason. Resident 36 stated the dinner last night was called, Turkey Surprise, and that it was so bad that she did not even eat one meal yesterday.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 465129	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/28/2024
NAME OF PROVIDER OR SUPPLIER Parkway Health Center		STREET ADDRESS, CITY, STATE, ZIP CODE 55 South Professional Way Payson, UT 84651	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 8/26/24 at 8:29 AM, an interview was conducted with resident 45. Resident 45 stated the food quality had gone down since the previous dietary manager left about three weeks ago. Resident 45 stated the quality was affected, the portion size had gotten smaller, what they serve did not match the menu, the food was served cold, and items would be missing from the meal and not supplemented. Resident 45 stated he was served two pieces of sliced bread with gravy on it yesterday for breakfast.</p> <p>43212</p> <p>On 8/25/24 at 10:38 AM, an interview was conducted with resident 9 who stated the food was not very good.</p> <p>On 8/25/24 at 11:05 AM, an interview was conducted with resident 29 who stated the food was terrible. Resident 29 stated residents filled out a menu for the week and the kitchen did not follow the menu.</p> <p>On 8/25/24 at 1:30 PM, an interview was conducted with resident 32 who stated dinner on the previous day was a casserole. Resident 32 stated the meal was cold and not good.</p> <p>On 8/25/24 at 2:53 PM, an interview was conducted with resident 34 who stated some of the meals were garbage. Resident 34 stated the lunch on the previous day was beef stroganoff which consisted of noodles in watery brown gravy with very little meat. Resident 34 stated dinner on the previous day was a broccoli and rice casserole.</p> <p>On 8/26/24 at 8:12 AM, an interview was conducted with the wife of resident 19 who stated the food quality was very poor. Resident 19's wife stated her husband ate very little of what was served because it was really bad.</p> <p>On 8/26/24 at 9:41 AM, an interview was conducted with resident 30 who stated the food was not always warm when it should be warm, or cold when it should be cold.</p> <p>On 8/27/24 at 11:53 AM, the trayline for the lunch meal was observed. At 12:17, a test tray was requested and sent out with the last meal cart. The results of the test tray included:</p> <ul style="list-style-type: none"> a. Pork chop, approximately 3 inches x 2.5 inches and .5 inches thick. The temperature of the meat was 117.5 degrees Fahrenheit, slightly tough, but could be chewed. The gravy on the meat tasted like cream of chicken soup. b. Noodles were tri-colored and had no flavor. The temperature was 111.0 degrees Fahrenheit. c. Broccoli was mushy and overcooked. There was no salt or seasoning. The temperature was 124.3 degrees Fahrenheit. d. Also on the menu was a dinner roll and pumpkin cake with cream cheese frosting. These menu items were not provided to the surveyor. <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 465129	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/28/2024
NAME OF PROVIDER OR SUPPLIER Parkway Health Center		STREET ADDRESS, CITY, STATE, ZIP CODE 55 South Professional Way Payson, UT 84651	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 8/28/24 at 12:17 PM, an interview was conducted with the Registered Dietitian (RD) who stated she conducted food quality audits weekly while she was in the building. The RD stated she did not know if she kept a record from her food audits. The RD stated she had spoken to one of the newer cooks after her last audit because there were a lot of palatability issues.</p> <p>On 8/28/24 at 1:52 PM, an interview was conducted with the Dietary Manager (DM) who stated she started a food council shortly after she was hired to address resident's immediate concerns. The DM stated she wanted to make sure the residents were happy. The DM stated one of the cooks needed some better training, especially for food presentation, following the menus and following the spreadsheets. The DM stated she had received complaints about the portion sizes of the food.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 465129	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/28/2024
NAME OF PROVIDER OR SUPPLIER Parkway Health Center		STREET ADDRESS, CITY, STATE, ZIP CODE 55 South Professional Way Payson, UT 84651	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>43212</p> <p>Based on observation and interview, the facility did not store, prepare, distribute and serve food in accordance with professional standards for food service safety. Specifically, food items in the walk-in freezer and walk-in refrigerator were not labeled and were open to air, personal items of kitchen staff were observed to be in the food preparation area, kitchen staff were handling food with bare hands, and the dish machine was not operating with water temperatures necessary to ensure the dishware was properly sanitized.</p> <p>Findings Include:</p> <p>On 8/25/24 at 9:25 AM, an initial walk-through was conducted in the kitchen. In the walk-in refrigerator, 4 packages of a green substance were found with no label and no date. In the walk-in freezer, a box of beef patties was open to air, and a box of cookie dough was open to air. An observation was made of the dish machine wash cycle during clean up from the breakfast meal. During the first observation, the wash temperature was 158 degrees Fahrenheit and the rinse temperature was 130 degrees Fahrenheit. In a second observation, the wash temperature was 154 degrees Fahrenheit and the rinse temperature was 130 degrees Fahrenheit. In a third observation, the was temperature was 150 degrees Fahrenheit and the rinse temperature was 130 degrees Fahrenheit. In a fourth observation, the wash temperature was 150 degrees Fahrenheit and the rinse temperature was 130 degrees Fahrenheit. An observation was made of the required temperatures posted on the dish machine. The wash temperature was required to be 160 degrees Fahrenheit or higher, and the rinse temperature was required to be 180 degrees Fahrenheit or higher. An observation was made of the dish machine temperature log. For the month of August, there were multiple days when the water temperature was not meeting the required temperature. The documentation was as follows, with all temperatures being in degrees Fahrenheit:</p> <p>a. On 8/1/24, for the lunch meal, the rinse temperature was 175.</p> <p>b. On 8/3/24, for the dinner meal, the wash temperature was 158 and the rinse temperature was 139.</p> <p>c. On 8/5/24, there were no temperatures documented for the dinner meal.</p> <p>d. On 8/7/24, for the breakfast meal, the rinse temperature was 177. For the dinner meal, the rinse temperature was 120.</p> <p>e. On 8/8/24, for the breakfast meal, the rinse temperature was 177. For the dinner meal, the rinse temperature was 174.</p> <p>f. On 8/9/24, for the breakfast meal, the rinse temperature was 160. For the lunch meal, the rinse temperature was 165. For the dinner meal, the wash temperature was 155 and the rinse temperature was 150.</p> <p>g. On 8/10/24, for the breakfast meal, the wash temperature was 135 and the rinse temperature was 150. For the dinner meal, the wash temperature was 151 and the rinse temperature was 135.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 465129	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/28/2024
NAME OF PROVIDER OR SUPPLIER Parkway Health Center		STREET ADDRESS, CITY, STATE, ZIP CODE 55 South Professional Way Payson, UT 84651	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>h. On 8/11/24, for the breakfast meal, the wash temperature was 155 and the rinse temperature was 165. For the lunch meal, the rinse temperature was 155. For the dinner meal, the rinse temperature was 165.</p> <p>i. On 8/12/24, for the breakfast meal, the rinse temperature was 171 degrees. For the lunch meal, the rinse temperature was 177 degrees. For the dinner meal, the wash temperature was 150 and the rinse temperature was 130.</p> <p>j. On 8/13/24, for the breakfast meal, the rinse temperature was 170. For the lunch meal, the rinse temperature was 175. For the dinner meal, the rinse temperature was 150.</p> <p>k. On 8/14/24, for the breakfast meal, the rinse temperature was 155. For the lunch meal, the rinse temperature was 155. For the dinner meal, the wash temperature was 149 and the rinse temperature was 130.</p> <p>l. On 8/15/24, for the breakfast meal, the rinse temperature was 173. For the dinner meal, the wash temperature was 155 and the rinse temperature was 163.</p> <p>m. On 8/16/24, for the breakfast meal, the rinse temperature was 155. For the lunch meal, the rinse temperature was 160 degrees. For the dinner meal, the rinse temperature was 160.</p> <p>n. On 8/17/24, for the breakfast meal, the rinse temperature was 170. There were not temperatures taken during the lunch meal. For the dinner meal, the wash temperature was 148 and the rinse temperature was 128.</p> <p>o. On 8/18/24, for the breakfast meal, the rinse temperature was 170. For the lunch meal, the rinse temperature was 170. For the dinner meal, the wash temperature was 155 and the rinse temperature was 129.</p> <p>p. On 8/19/24, for the breakfast meal, the rinse temperature was 175. For the dinner meal, the wash temperature was 156 and the rinse temperature was 143.</p> <p>q. On 8/20/24, for the breakfast meal, the rinse temperature was 177. For the dinner meal, the wash temperature was 155 and the rinse temperature was 165.</p> <p>r. On 8/21/24, for the breakfast meal, the rinse temperature was 176.</p> <p>s. On 8/22/24, for the breakfast meal, the rinse temperature was 175.</p> <p>t. On 8/23/24, for the breakfast meal, the rinse temperature was 170. For the dinner meal, the wash temperature was 140 and the rinse temperature was 158.</p> <p>u. On 8/24/24, there were no temperature taken for the breakfast and lunch meals. For the dinner meal, the wash temperature was 156 and the rinse temperature was 133.</p> <p>v. On 8/25/24, for the breakfast meal, the rinse temperature was 165. There were no temperatures taken for the lunch and dinner meals.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 465129	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/28/2024
NAME OF PROVIDER OR SUPPLIER Parkway Health Center		STREET ADDRESS, CITY, STATE, ZIP CODE 55 South Professional Way Payson, UT 84651	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>It should be noted that while making the first observations of the dish machine temperatures, Dietary Aide (DA) 1 was observed to take the plate covers as they came out of the dish machine and put them on the shelf in preparation for the next meal.</p> <p>On 8/25/24 at 10:01 AM, an observation was made of a soda can and a small clutch bag sitting on the surface next to the griddle. A small office caddy was also on that surface with a pad of sticky notes in it.</p> <p>On 8/27/24 at 11:16 AM, an observation was made of the morning/afternoon cook (CK) 1 who was pulling apart dinner rolls for the lunch meal with her bare hands. CK 1 placed some of the dinner rolls into a bag, went to the sink to wash her hands, and then took the bag to the meal cart and placed a dinner roll on each tray within the dinner cart. CK 1 then returned to the tray of rolls and began pulling them apart with her bare hands.</p> <p>On 8/27/24 at 11:29 AM, an observation was made of the dish machine while cleaning dishes. The wash temperature was 145 degrees Fahrenheit, and the rinse temperature was 175 degrees Fahrenheit.</p> <p>On 8/27/24 at 11:34 AM, an observation was made of 2 large drinking cups sitting on the area right next to the griddle. Also on that surface was an office cup with large clips, an office tray with sticky notes, kitchen gloves, a clip board and a dietary form.</p> <p>On 8/27/24 at 11:37 AM, an observation was made of the stove in the kitchen which had food splatter on it. The griddle had crumbs on the area under the knobs and where the griddle was turned on and off.</p> <p>On 8/27/24 at 12:09 PM, an observation was made of CK 1 who was filling small cups with brown sugar. CK 1 was observed with a small cup of brown sugar in her hand and with a bare finger, smoothed off and patted down the brown sugar in the cup before putting a lid on it and obtaining another small cup of brown sugar.</p> <p>On 8/28/24 at 1:19 PM, a second walk-through of the kitchen was conducted. In the walk-in freezer, a box of Salisbury steak patties was open to air, a box of meat patties was open to air, a box with chocolate chip cookie dough was open to air, a box of sugar cookies was open to air. There were 7 individual pot pies stacked on a shelf that were not dated. In the walk-in refrigerator, a box of bacon was open to air. A container of lime juice with a best by date of 4/7/24. Additionally, a 5 gallon bucket of dill pickle spears had a lid on top, but it was not sealed and was open to air. On the surface next to the griddle, a bag of candy was observed, a drinking cup was observed as well as a box of gloves, an office tray with sticky notes, a cup containing highlighters, pens and pencils, and a labeling gun. On a shelf above the stove, a box of creamy wheat cereal was observed to be open to air. In the dry storage room, a container of long grain rice was open to air. A white substance was observed to have dripped into a large mixing bowl and was hardened. The ovens were observed to have crumbs outside the doors on the flat surfaces. The stove had dried food around the burners and the grill was greasy on top.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 465129	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/28/2024
NAME OF PROVIDER OR SUPPLIER Parkway Health Center		STREET ADDRESS, CITY, STATE, ZIP CODE 55 South Professional Way Payson, UT 84651	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>On 8/25/24 at 9:56 AM, an interview was conducted with DA 1 who stated if there was a problem with dish machine temperatures, she would notify the dietary manager who would then call and have it repaired. DA 1 stated the temperatures were checked before running the dishes through the dish machine and were not checked again until the next meal. The DA stated she did not monitor the temperatures on the machine while the dishes were being cleaned.</p> <p>On 8/26/24 at 8:40 AM, an interview was conducted with the DM who stated the dish machine was a high temperature machine. The DM stated temperatures were taken before each set of dishes started. The DM stated she was unsure what the temperatures were supposed to be. The DM looked on her computer and was unable to find what the temperatures should be. The DM stated if the temperatures were not meeting the required temperatures, she would call (company name) to fix it. During the interview an observation was made of the dishwasher during a cycle. The wash temperature was observed to be 160 degrees Fahrenheit, and the rinse temperature was 142 degrees Fahrenheit.</p> <p>On 8/27/24 at 11:41 AM, an interview was conducted with DA 2 who stated she checked the temperature of the dish machine right after the breakfast meal. DA 2 stated the dish machine had to be run a few times before running the dishes so it would get to the proper temperature. DA 2 showed the surveyor the thermometer on the dish machine where the temperatures were taken. DA 2 stated the wash cycle was supposed to be above 160 degrees Fahrenheit, DA 2 stated the temperature required for the rinse cycle was 180-185 degrees Fahrenheit. DA 2 stated if the temperatures were not meeting required levels, the maintenance manager was supposed to be called to fix the machine. DA 2 stated it was her opinion that the staff running the machine at night were just turning the machine on and running the dishes. DA 2 stated she thought the DM checked the temperature logs. DA 2 stated the reason for having temperature controls was to ensure the dishes were being sanitized and to prevent food borne bacteria. DA 2 stated the temperatures documented at the dinner meal the night before were not adequate to sanitize the dishes. The temperatures for the dinner meal on 8/26/24 were 140 degrees Fahrenheit for the wash cycle and 130 degrees Fahrenheit for the rinse cycle.</p> <p>On 8/28/24 at 12:17 PM, an interview was conducted with the RD. The RD stated she completed a monthly kitchen audit, and completed a more in-depth quarterly audit of the kitchen that included sanitation, budget and meal service. The RD stated she looked at the dish machine and other temperature logs monthly and had been checking weekly while they did not have a DM. The RD stated she had noticed, last year, that the dish machine temperatures were not meeting the requirements, and was told by kitchen staff that the machine had been fixed. The DM stated she was told the machine was fixed in April 2024. The RD stated she did not keep copies of the temperature logs, but that they should be kept in a binder in the kitchen. The RD stated previously when the temperatures were not meeting requirements, she and the administrator were notified and the repair company came and fixed the machine. The RD stated she did not believe the facility maintenance manager did any maintenance on the machine.</p> <p>On 8/28/24 at 1:46 PM, an interview was conducted with CK 2 who stated the new DM had not yet made up cleaning schedules yet, so the kitchen staff were just cleaning up after themselves and when they saw something that needed to be done.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 465129	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/28/2024
NAME OF PROVIDER OR SUPPLIER Parkway Health Center		STREET ADDRESS, CITY, STATE, ZIP CODE 55 South Professional Way Payson, UT 84651	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>On 8/28/24 at 1:52 PM, an interview was conducted with the DM who stated she had been notified about the dish machine temperatures. The DM stated (company name) should have come on 8/27/24 and fixed the dish machine. The DM stated she would call the repair man to see what was found. The DM stated food items in the freezer should have a date when it was opened and used within the next week. The DM stated the food in the freezer and the refrigerator should be sealed. The DM stated food open to air can result in residents becoming sick, and affects the quality of food. The DM stated she would have to get back to the surveyor regarding a cleaning schedule.</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 465129	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/28/2024
NAME OF PROVIDER OR SUPPLIER Parkway Health Center		STREET ADDRESS, CITY, STATE, ZIP CODE 55 South Professional Way Payson, UT 84651	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0867</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action.</p> <p>43212</p> <p>Based on interview, record review, and observation, the facility did not establish and implement written policies and procedures for feedback, data collections systems and monitoring to include adverse event monitoring. Specifically, on the previous recertification survey conducted on 10/3/22, F609, F697, F755, F761, F804, F812, F867, and F880 were cited. These deficiencies were cited again during the current recertification survey. Resident identifiers: 4, 5, 8, 9, 12, 14, 15, 16, 19, 21, 23, 28, 29, 30, 32, 34, 36, 38, 39, 45, 48, 53, 156, 158, 161, 166, and 206.</p> <p>Findings include:</p> <p>a. Based on observation, interview, and record review, for 2 of 42 residents sampled, the facility did not ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source, were reported immediately, but not later than 2 hours after the allegation was made, to the State Survey Agency. Specifically, a resident had a fall while in a mechanical lift and was not reported to the State Survey Agency and a resident had a fall which resulted in a fracture and the State Survey Agency was not notified within 2 hours after the allegation was identified. Resident identifiers: 28 and 156.</p> <p>Reference [609]</p> <p>b. Based on observation, interview, and record review, the facility did not ensure that pain management was provided to residents who required such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals preferences. Specifically, for 1 out of 42 sampled residents, a resident was observed to complain about pain and pain medications were not available. Resident identifier: 16.</p> <p>Reference [697]</p> <p>c. Based on interview and record review it was determined, for 1 of 42 sampled residents, that the facility did not provide routine and emergency drugs and biological's to its residents. Specifically, a resident was not administered medications as ordered by the physician due to the medications not being available by the pharmacy. Resident identifier: 16</p> <p>Reference [755]</p> <p>d. Based on observation and interview it was determined that the facility did not label all drugs and biological's used in the facility in accordance with currently accepted professional principles, and include appropriate accessory instructions and the expiration date when applicable. Specifically, medication carts were left unlocked and unattended, insulin pens were open and available for use past the expiration date. In addition, narcotics were repackaged into the narcotic cards.</p> <p>Resident Identifiers: 4, 5, 15, 21, 23, 34, 38, 39 and 48.</p> <p>Reference [761]</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 465129	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/28/2024
NAME OF PROVIDER OR SUPPLIER Parkway Health Center		STREET ADDRESS, CITY, STATE, ZIP CODE 55 South Professional Way Payson, UT 84651	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0867</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>e. Based on observation, interview and record review, the facility did not provide food prepared by methods that conserve flavor and appearance or provide food and drink that is palatable, attractive, and at an appetizing temperature. Specifically, there were multiple complaints from residents about the quality of the food, and when surveyors pulled a test tray during the lunch meal, the food was found to be lacking in flavor and appearance. Resident identifiers: 4, 8, 9, 12, 19, 29, 30, 32, 34, 36, 39, 45, 166 and 206.</p> <p>Reference [804]</p> <p>f. Based on observation and interview, the facility did not store, prepare, distribute and serve food in accordance with professional standards for food service safety. Specifically, food items in the walk-in freezer and walk-in refrigerator were not labeled and were open to air, personal items of kitchen staff were observed to be in the food preparation area, kitchen staff were handling food with bare hands, and the dish machine was not operating with water temperatures necessary to ensure the dishware was properly sanitized.</p> <p>Reference [812]</p> <p>g. Based on interview, record review, and observation, the facility did not establish and implement written policies and procedures for feedback, data collections systems and monitoring to include adverse event monitoring.</p> <p>Reference [867]</p> <p>h. Based on observation and interview it was determined, the facility did not establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. Specifically, for 2 out of 42 sampled residents, a staff member was observed to touch a resident medications with bare hands with each medication administration.</p> <p>Reference [880]</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 465129	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/28/2024
NAME OF PROVIDER OR SUPPLIER Parkway Health Center		STREET ADDRESS, CITY, STATE, ZIP CODE 55 South Professional Way Payson, UT 84651	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0867</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 8/28/24 at 3:54 PM, an interview was conducted with the Administrator (ADM). The ADM stated the medical director, leadership personnel, administration, medical records, the MDS [minimum data set] coordinator, the Dietary Manager (DM), therapy staff, activities director, and maintenance attended the Quality Assessment and Performance Improvement {QAPI} meetings. The ADM stated the committee met on Wednesday of every month. The ADM stated documentation of the meetings were on signature pages that were placed in the QAPI binder and meeting notes that were kept in the computer. The ADM stated during a meeting an agenda was followed to cover areas of importance. The ADM stated a quick base program was being used to look for trends, and the reporting system was used to keep track of issues. The ADM stated action plans or PIPs (performance improvement plans) were established for issues that needed to be addressed at the time. The ADM stated that audit tools and check systems were reviewed at every QAPI meeting. The ADM stated that between QAPI meetings administrative staff followed up on things. The ADM stated staff education was provided on the third Tuesday of every month. The ADM stated in the previous month a lot of time was spent on abuse and reporting. The ADM stated actions that were currently being taken to ensure quality care for the residents were addressing staffing issues and training of staff. The ADM stated the PIP that was currently being worked on was abuse and reporting, specifically identifying the causes, asking questions, and obtaining statements from staff and other residents during the investigations. The ADM stated falls, care plans, charting and communications were also being worked on. The ADM also stated better management of labs, being consistent on getting results and reviewing them, cleaning resident rooms, obtaining POLST (Provider Order for Life-Sustaining Treatment) forms and advanced directives, decreasing Urinary Tract Infections (UTIs), and better infection control measures. The ADM stated nothing specific had been done to address medication administration.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 465129	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/28/2024
NAME OF PROVIDER OR SUPPLIER Parkway Health Center		STREET ADDRESS, CITY, STATE, ZIP CODE 55 South Professional Way Payson, UT 84651	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p>44640</p> <p>Based on observation and interview it was determined, the facility did not establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. Specifically, for 2 out of 42 sampled residents, a staff member was observed to touch a resident medications with bare hands with each medication administration.</p> <p>Findings include:</p> <p>On 8/27/24 at 7:45 AM, during morning medication pass the following was observed:</p> <p>a. At 7:48 AM, Registered Nurse (RN) 2 was observed to not use hand hygiene prior to starting medication pass. RN 2 was observed to use push a medication through the medication pack with his right hand into the palm of his left hand before he placed the medication into the medication cup using bare fingers. The medication was administered to resident 14.</p> <p>b. At 7:50 AM, RN 2 was observed to pour a medication out of a bottle into his left palm and use bare fingers to pick up the medication and place it into the medication cup. No hand hygiene was observed to be used. The medication was administered to resident 14.</p> <p>c. At 8:05 AM, RN 2 was observed to pour an over the counter medication from a bottle into the palm of his hand and pick up the medication and place it into a medication cup. No hand hygiene was observed to be used. The medication was administered to a resident.</p> <p>On 8/27/24 at 8:08 AM, an interview was conducted with RN 2. RN 2 stated that hand hygiene should be done before and after each medication pass. RN 2 stated touching the medications bare handed was not supposed to happen.</p> <p>On 8/27/24 at 8:35 AM, an interview was conducted with RN 3. RN 3 stated hand hygiene should be used all the time during medication pass. RN 3 stated touching the medications with bare hands was not ok and should not be done.</p> <p>On 8/27/24 at 9:18 AM, an interview was conducted with the Director of Nursing (DON). The DON stated the staff are expected to use hand hygiene during medication pass. The DON stated the nurses should not touch the medications with bare hands and can wear gloves if they were clean and used only for one patient at a time.</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 465129	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/28/2024
NAME OF PROVIDER OR SUPPLIER Parkway Health Center		STREET ADDRESS, CITY, STATE, ZIP CODE 55 South Professional Way Payson, UT 84651	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0925</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>48709</p> <p>Make sure there is a pest control program to prevent/deal with mice, insects, or other pests.</p> <p>Based on observation and interview it was determined the facility did not maintain an effective pest control program so that the facility was free of pests. Specifically, residents complained of and were observed to have flies around and on them. Resident identifiers: 2, 5, 6, 24, 37 and 40.</p> <p>Findings include:</p> <p>On 8/25/24 at 10:24 AM, an observation and interview was conducted with resident 24. Resident 24 was in her room sitting in a wheelchair next to her bed, a fly swatter was observed in her room. Two flies were observed in her room, one was on resident 24's knee. Resident 24 stated that staff knew about the flies and that the flies were a pain. Resident 24 stated the flies had been bad for months and that she was going to buy some bug spray.</p> <p>On 8/25/24 at 10:43 AM, an observation and interview was conducted with resident 2. Resident 2 was laying in bed in her room. Two flies were observed on resident 2's feet during the interview. Resident 2 stated there were a lot of flies at the facility and that they needed to spray. One fly was observed to land on resident 2's face.</p> <p>On 8/25/24 at 11:10 AM, an interview was conducted with resident 37. Resident 37 stated she could hear her roommate, resident 2, yell at the flies.</p> <p>On 8/25/24 at 11:42 AM, an interview was conducted with resident 6. A fly swatter was observed within reach of the resident and resident 6 stated there were flies everywhere and he had been trying to get rid of them.</p> <p>On 8/25/24 at 1:31 PM, an observation and interview was conducted with resident 5. Resident 5 was in her room. During the interview two flies were observed to fly around the resident's face and land on her arm. Resident 5 stated she had a fly swatter to help with the flies and that the facility was supposed to put stuff on the walls to attract the flies but that the flies were pretty bad. Resident 5 stated the doors are opened constantly.</p> <p>On 8/26/24 at 1:11 PM, an observation was made in the dining area near 400 hall. There were 3 flies observed, 2 of which landed on a dining table.</p> <p>On 8/26/24 at 1:40 PM, an interview was conducted with Certified Nurse Assistant (CNA) 2. CNA 2 stated the flies are worse near the 400 hall because a lot of smokers go inside and outside in this area. CNA 2 stated one of the prizes for bingo was a fly swatter. CNA 2 stated he tried to keep the doors and windows closed. CNA 2 stated he would swat flies when residents asked him to.</p> <p>On 8/28/24 at 8:20 AM, an interview was conducted with the Maintenance Director (MD). The MD stated the residents do not like the flies and that the flies had increased because the smokers go outside and opened the doors. The MD stated a fly light had been placed over the fridge in long term and resident's had bought their own fly swatters and lights for their rooms.</p> <p>43212</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 465129	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/28/2024
NAME OF PROVIDER OR SUPPLIER Parkway Health Center		STREET ADDRESS, CITY, STATE, ZIP CODE 55 South Professional Way Payson, UT 84651	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0925</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 8/26/24 at 11:11 AM, an observation and interview was conducted with resident 40 who stated she hated the flies that were in her room. Resident 40 stated she thought the flies were disgusting. Resident 40 stated it was rude to not resolve the problem. Resident 40 stated , residents do not like eating with flies all over the place.</p>		