

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555596	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/30/2025
NAME OF PROVIDER OR SUPPLIER Parkside Health and Wellness Center		STREET ADDRESS, CITY, STATE, ZIP CODE 444 W Lexington El Cajon, CA 92020	

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 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>45909</p> <p>Based on observation, interview, and record review, the facility failed to ensure two residents (Resident 31 and Resident 10) were treated with dignity and respect when</p> <ul style="list-style-type: none"> - Resident 30 and Resident 10 were not offered a table to dine in the dining room with other residents. -Residents 30 and 10 ate their meal at a table that was not clean. <p>These failures had the potential to affect residents' psychosocial well-being related to dignity and respect.</p> <p>Findings:</p> <p>A dining observation and interview was conducted with Resident 31 on 5/27/25 at 11:36 A.M. in the dining room. Resident 31 and Resident 10 were both seated on a chair waiting for other residents to vacate a table so that they may eat. Resident 31 stated that he was frustrated to wait for a table to be vacated.</p> <p>During a follow-up observation on 5/27/25 at 11:47 A.M. in the dining room, Resident 31 and Resident 10 stood up and took open seats vacated by other residents who were finished eating. The tablecloth was observed filled with food debris from the previous residents who ate at the table.</p> <p>An interview was conducted with certified nursing assistant (CNA) 2 on 5/27/25 at 12:05 P.M. CNA 2 acknowledged that Resident 31 and Resident 10 waited for other residents to leave the table to have lunch. CNA 2 further stated that staff should have offered an available clean table to Resident 31 and Resident 10 when they entered the dining room.</p> <p>An interview was conducted with the Director of Nursing (DON) on 5/29/25 at 3:15 P.M. The DON stated that all residents should have a clean table available at mealtime. The DON further stated that staff should have offered and directed Resident 31 and Resident 10 to a clean table to eat.</p> <p>Per the facility's undated policy titled Dignity and Respect, It is the policy of this facility that all residents be treated with kindness, dignity and respect.</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
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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45909</p> <p>Based on observation, interview, and record review, the facility failed to provide adequate services for prevention of a pressure ulcer (PU - injury to the skin and underlying tissue resulting from prolonged pressure) for one of two sampled residents (Resident 1). This failure had the potential for Resident 1 to develop a PU.</p> <p>Findings:</p> <p>Resident 1 was admitted to the facility on [DATE] per the facility's Resident Face Sheet, with diagnoses of osteoarthritis (joint disease that causes loss of mobility) and dementia (memory problem).</p> <p>A review of Resident 1's nursing care plan (NCP - detailed nursing care that a resident receives) dated 5/27/24 indicated, Resident 1 will only sit on the wheelchair with foam for maximum of 2 hours.</p> <p>During an initial observation on 5/27/25 at 8:13 A.M., Resident 1 was observed sitting on her wheelchair in her bedroom.</p> <p>Observations were conducted on 5/27/25 at 10:13 A.M. and 1:15 P.M. Resident 1 was observed sitting on her wheelchair in her bedroom.</p> <p>A follow-up observation and interview was conducted on 5/27/25 at 3:15 P.M. with certified nursing assistant (CNA) 1. Resident 1 was sitting on her wheelchair in her bedroom. CNA 1 acknowledged that Resident 1 had been sitting on her wheelchair since that morning. CNA 1 further stated that Resident 1 should have been off the wheelchair to prevent the development of a PU.</p> <p>A concurrent interview and record review was conducted with licensed nurse (LN) 1 on 5/29/25 at 1:14 P.M. Resident 1's Braden Assessment (tool used to assess a resident's risk of developing PU), dated 5/6/25 indicated that Resident 1 had a high risk for developing a PU. LN 1 further stated that Resident 1 should have been on her wheelchair only for two hours, per Resident 1's NCP. There was no indication in Resident 1's record that Resident 1 refused care.</p> <p>An interview was conducted with the Director of Nursing (DON) on 5/29/25 at 3:30 P.M. The DON stated that the NCP should be implemented by nursing staff to address the care needed by residents. The DON further stated that Resident 1 should have been assisted off her wheelchair after two hours, to prevent the development of a PU.</p> <p>The facility's policy titled, Skin and Wound Monitoring and Management dated 3/2025, indicated .3. Prevention: In order to prevent pressure injuries, nursing staff shall implement, monitor impact of interventions and modify interventions as appropriate .</p>		

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<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>45909</p> <p>Based on observation, interview, and record review, the facility failed to ensure a cook followed the standardized recipe for sauce preparation. This failure had the potential to affect food palatability (referred to the pleasantness of taste; may influence behavior, particularly concerning the drive to eat) for 48 residents.</p> <p>Findings:</p> <p>A review of the lunch recipe scheduled on 5/29/25 indicated, for 48 residents: Teriyaki Fish. Sauce: Low sodium soy sauce 1 1/2 cups.</p> <p>During a food preparation observation and interview in the kitchen on 5/29/25 at 9:55 A.M., the dietary cook (DC) poured 1 1/4 cups of low sodium soy sauce into a measuring cup. The DC stated that there was 1 1/4 cups of low sodium soy sauce in the measuring cup to make the teriyaki sauce. The DC poured the cup contents into the cooking pan.</p> <p>During an interview with the dietary manager (DM) on 5/29/25 at 1:15 P.M., the DM stated that the DC should follow all recipes approved by the registered dietitian. The DM further stated that the DC should have reviewed the recipe and should have poured 1 1/2 cups of low sodium soy sauce to ensure food flavor and nutritional consistency was maintained.</p> <p>The facility's policy titled, Food Preparation, dated 2023, indicated, Procedure 1. The facility will use approved recipes, standardized to meet the resident census .</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50175</p> <p>Based on observation, interview, and record review, the facility failed to ensure a nasal cannula (a flexible tubing that delivers oxygen via the nose) was labeled with a date, for one of 13 sampled residents (Resident 21).</p> <p>This failure had the potential for oxygen tubing to be used past the recommended date, increasing the potential for bacteria to form inside the nasal cannula and potentially cause respiratory infection to Resident 21.</p> <p>Findings:</p> <p>Resident 21 was admitted to the facility on [DATE] with diagnoses which included chronic respiratory failure (a disease causing difficulty breathing) and chronic obstructive pulmonary disease (a lung disease), per the facility's Admission Record.</p> <p>On 5/27/25 at 11:45 A.M., a nasal cannula attached directly to an oxygen concentrator (a machine that delivers oxygen) was observed at Resident 21's bedside. The nasal cannula was not dated or labeled.</p> <p>A review of Resident 21's medical record was conducted on 5/28/25. A review of the physician's orders indicated Resident 21 needed continuous oxygen therapy.</p> <p>An interview was conducted with License Nurse (LN) 12 on 5/29/25 at 2:36 P.M. LN 12 verified that there was no date on the nasal cannula tubing. LN 12 stated that the nasal cannula tubing should have had a date and it should have been connected to a humidifier. LN 12 stated it was important to include a date on the tubing because it would indicate when the tubing needed to be changed. LN 12 stated that the nasal cannula tubing should be changed every seven days. LN 12 stated it was important to change the nasal cannula tubing every seven days for infection control, to prevent a buildup of bacteria in the tubing, and prevent Resident 21 from developing a respiratory infection.</p> <p>An interview was conducted with the Infection Preventionist (IP) on 5/29/25 at 2:44 P.M. The IP acknowledged that the nasal cannula tubing should be dated and changed every seven days. The IP stated it was important to change the nasal cannula for infection control and to prevent respiratory infections. The IP stated it was part of the facility's guideline to change the nasal cannula every seven days.</p> <p>An interview was conducted with the Director of Nursing (DON) on 5/29/25 at 2:53 P.M. The DON stated that Resident 21 should have a clean nasal cannula. The DON acknowledged that it was important to date the nasal cannula tubing, to know when it should be changed.</p> <p>A review of the facility's undated policy and procedure titled Oxygen Administration (Mask, Cannula, Catheter) did not indicate the guideline of when oxygen tubing should be changed.</p>		