STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465129	A. Building B. Wing	10/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Parkway Health Center	55 South Professional Way Payson, UT 84651

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38031 Based on observation, interview, and record review it was determined, for 1 out of 34 sampled residents, that the facility did not ensure that the resident could exercise their rights without interference, coercion, discrimination, or reprisal from the facility. Specifically, a resident was denied access to their cigarettes and had their quantity of cigarettes limited when the resident asked for more. Resident identifier: 8. Findings included: Resident 8 was admitted to the facility on [DATE] with diagnoses which included dementia without behavioral disturbance, hypokalemia, type 2 diabetes mellitus, chronic pain syndrome, hypertension, hypothyroidism, urinary tract infection, muscle weakness, abnormalities of gait and mobility, and hyperlipidemia. On 6/16/22, resident 8's Admission Minimum Data Set assessment documented a Brief Interview of Mental Status of 8/15, which indicated moderately cognitively impaired. The assessment did not address the short-term and long-term memory. The assessment documented that resident 8 was a limited one person assistance for walking in room and in the corridor and was supervision with setup assistance for locomotion on and off the unit. The mobility devices used were documented as a walker and wheelchair. On 8/15/22, a Smoking Risk assessment was completed for resident 8. Resident 8's assessment documented that resident 8 borrowed cigarettes and a lighter from others and smoked every few hours. The assessment documented that resident 8 scored a 1, which indicated a minimal problem for the following areas: smoking in unauthorized areas; was careless with smoking materials - drops cigarette butts or matches on floor, furniture, self or others; burns finger tips; burns clothes; smokes near oxygen; smokes in the facility; inappropriately provided smoking materials to others; general awareness and ability to understand the facility safe smoking policy; and capability to follow the safe smoking policy. The assessment documented that resident 8 scored a 3 or severe problem with begging or stealing smoking materials from others. The assessment documented a total score of 10 which indicated a potentially unsafe smoker. (continued on next page)

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

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	465129	A. Building B. Wing	10/03/2022

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A second undated smoking assessment documented that resident 8's total score of 6, which would indicate safe to smoke. The assessment documented that resident 8 scored a 3 or moderate problem for smokes cigarettes/butts from the ash tray and begs or steals smoking materials from others. The assessment documented a score of 1 which indicated a minimal problem for general behavior and interpersonal interaction, and mobility. The assessment documented that resident 8 was not ready to accept smoking cessation materials. No documentation could be found that indicated that resident 8 had a Power of Attorney (POA). Review of resident 8's progress notes revealed the following: a. On 8/25/22 at 1:25 PM, the nurse practitioner's (NP) note documented that resident 8 was pleasantly confused. will often forget where she's going or where she is at. b. On 8/25/22 at 5:21 PM, the nurse's note documented, pt [patient] given baggie of 7 cigarettes this morning at 0700 [7:00 AM] and within two hours had smoked all 7 and trying to borrow cigarettes' from other patients and redirected multiple times, other patients stating she only gets two cigarettes a day and pt educated again on how many she gets and counted baggies in med [medication] cart with her with 7 in each bag for the week days. c. On 9/4/22 at 10:31 AM, the nurse's note documented, pt is out of cigarettes since Friday and son will not bring her cigarettes or money for cigarettes, patient notified and appears not happy. circling the outside building and outside trash cans looking for cigarette butts and unable to re-direct, tiger text sent to all staff r/t [related to] the above. d. On 9/9/22 at 10 :56 AM, the nurse's note documented, Cigarettes in nursing cart. Pt. has had 2 as of 11am; one at 8:30am, one at 10:30am. e. On 9/15/22 at 5:35 AM, the NP note documented, . remains confused. she continues to lack her own safety awareness. no new falls or other events. f. On 9/18/22 at 3:58 PM, the nurse's note documented, pts [family member] came in and brought one pack of cigarettes labeled and in top drawer and try to space them out he said one every few hours and pt educated again, pts [family member] says he plans on taking her home soon but trying to figure out logistics first and then will notify social worker and facility. Review of resident 8's care plan revealed a care area for tobacco use that was initiated on 9/27/22. Interventions identified were to distract with an activity or conversation of choice when it was not smoking time; offer cessation information as desired; involve support person or Ombudsman as needed; praise the resident for being safe and responsible; resident will be able to follow the smoking policy with staff assistance; and resident will not share or borrow tobacco products or paraphernalia from other. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/26/22 at 10:21 AM, an interview was conducted with Certified Nurse Assistant (CNA) 1. CNA 1 stated that resident 8 was confused and had some short-term memory deficits. CNA 1 stated that resident 8 knew where she was at and understood what was going on. CNA 1 stated that resident 8 wandered and went for walks around the building. CNA 1 stated that resident 8 used a cane for a mobility device. CNA 1 stated that resident 8 was frequently outside smoking and would wander to the other side of the building to look at the baby horse. On 9/27/22 at 1:30 PM, an observation was made of resident 8 asking the Registered Nurse (RN) for a cigarette. The RN was observed to tell resident 8 that they just had one and that they had to wait until 4:00 PM for the next one. On 9/27/22 at 1:32 PM, an interview was conducted with RN 4. RN 4 stated that resident 8 asked for a cigarette and was told that she had to wait until 4:00 PM because she had one at 1:00 PM already. RN 4 stated that she told resident 8 that she had nine cigarettes remaining. RN 4 stated that resident 8's cigarettes were kept inside the medication cart, but not the lighter. RN 4 stated that resident 8 went through packs of cigarettes fast so they were trying to limit the amount she smoked. RN 4 stated that resident 8 had a cigarette at 1:00 PM and then returned immediately to ask for a second one. RN 4 stated that she reminded resident 8 that she had just smoked a cigarette and that she needed to wait until 4:00 PM for the next one. RN 4 stated that she was told in report by the previous nurse that resident 8 was to only have one cigarette every three hours. RN 4 stated that resident 8 smoked independently and that she was alert and oriented to person and place. RN 4 stated she was not sure if resident 8 was able to make her own decisions, or if she had that capacity. RN 4 stated that resident 8 did not have all her faculties. RN 4 stated that she was not sure if resident 8 was her own responsible party or if she had a POA. RN 4 stated that resident 8 wandered and went outside to smoke. On 9/28/22 at 8:41 AM, an interview was conducted with RN 5. RN 5 stated that resident 8 could only have one cigarette every two hours. RN 5 stated that resident 8 would forget that she had smoked. RN 5 stated that resident 8's family were in control of the cigarettes and had set the schedule for smoking. On 9/29/22 at 8:27 AM, an interview was conducted with CNA 2 and Restorative Nurse Assistant (RNA) 1. CNA 2 stated that resident 8 had a fall outside three or four months ago. CNA 2 stated the staff made sure to keep an eye on where resident 8 was going and made sure she did not go into the construction site that was nearby. CNA 2 stated that the staff would keep track of resident 8 by looking out the windows to find her. CNA 2 stated that resident 8 had wandered into the construction area before to ask for cigarettes. CNA 2 stated that this had happened multiple times within a two week period. CNA 2 stated that this occurred before resident 8 had her own cigarettes. CNA 2 stated that since resident 8 had access to her own cigarettes she had not wandered back over to the construction site. CNA 2 stated that resident 8 was an independent smoker and had her lighter in her possession. RNA 1 stated that resident 8's routine was to walk around the parameter of the building. RNA 1 stated that resident 8's family made the smoking schedule and limited her cigarettes. RNA 1 stated that resident 8 would smoke the whole pack because she forgets. RNA 1 stated she was not aware of resident 8's POA status. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/29/22 at 11:06 AM, an interview was conducted with the Director of Nursing (DON). The DON stated that resident 8's cognitive status was that she was alert and able to answer questions. The DON stated that resident 8 had aphasia and had difficulty with her speech. The DON stated that resident 8 was able to ask for things that she needed, could speak using more than one word, but did not talk with full sentences. The DON stated that resident 8 frequently asked for Pepsi but did not necessarily mean Pepsi when asked if that was what she wanted. The DON stated that the staff would then have to go through other items that may be wanted. The DON stated that resident 8 was able to make decisions about her care and could express her wants and needs. The DON stated that she was not sure if resident 8 had a POA. The DON stated that the family were involved in resident 8's care but did not know if they made decisions about resident 8's care for her The DON stated she did not know if the family directed the smoking schedule for resident 8. The DON stated she was not aware of any smoking schedule or cigarette limitations for resident 8. The DON stated that every resident who smoked should have a smoking assessment completed. On 9/29/22 at 12:36 PM, a follow-up interview was conducted with the DON, the Corporate Social Service Worker (CSSW), and the Resident Advocate (RA). The DON stated that she had observed that the second smoking assessment was not dated. The DON stated that the smoking assessment with a score of 6 was dated on 7/14/22, and the most recent assessment was on 8/15/22. The DON stated that the smoking assessment that scored a 10, which indicated that resident 8 was potentially an unsafe smoker, was the most recent assessment. The CSSW stated that the RA conducted resident 8's smoking assessments. The DON stated that it should be an Interdisciplinary Team decision on resident 8's interventions for smoking. The DON stated that the biggest challenge was that resident 8 tried to get smoking materials from others and the ashtrays. The DON stated that resident 8 would seek cigarettes when they were not available. The CSSW stated that resident 8 did not have a POA. The CSSW stated that a family member had said they were resident 8's POA, but they had not provided the documents for it. The CSSW stated that the family purchased the cigarettes for resident 8 and had asked the facility to limit the amount that was provided to resident 8. The RA stated that she conducted the smoking assessment and observed resident 8 to safely light, smoke, and dispose of the cigarette. The RA stated that based on the observation she determined that resident 8 would need staff supervision for smoking to ensure that she did not dig through the ashtray seeking more cigarettes. The RA stated that she educated the staff to manage resident 8's cigarettes, so she was not blowing through them. The RA stated that a family member requested that they manage resident 8's cigarettes because they could not afford to bring her packs every day. The RA stated that the family member would bring two packs in and say that they needed to last until a certain day. The RA stated that resident 8 would be able to recall that those two packs had to last a certain amount of time. The RA stated, I don't think we restricted them. The RA stated that per the family request if resident 8 smoked them all in two days so be it.

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	465129	A. Building B. Wing	10/03/2022

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30563 Based on observation, interview, and record review, it was determined, the facility did not ensure that the resident's right to self-administer medications was evaluated and determined to be safe. Specifically, for 2 out of 34 sampled residents, resident's had medications stored in their rooms without an evaluation to determine if the resident's were safe to self-administer medications. Resident identifiers: 25 and 48. Findings included: 1. Resident 25 was admitted to the facility on [DATE] with diagnoses which included hypothyroidism, hyperlipidemia, depression, hypertension, borderline personality disorder, gastroesophageal reflux disease, pain, and edema. On 9/26/22 at 12:32 PM, an observation was made of resident 25. Resident 25 had an inhaler in a box on her over bed table. Resident 25 was interviewed. Resident 25 stated she needed the inhaler off and on. Resident 25 stated she had the inhaler in her purse and brought it out so she had it when she needed it. Resident 25 stated she could not rely on staff to provide the inhaler when she needed it because there were not enough staff. Resident 25's medical record was reviewed on 9/28/22. There was no self administration assessment located in resident 25's medical record to determine if resident 25 was able to administer her own medications safely. 2. Resident 48 was admitted to the facility on [DATE] with diagnoses which included alcoholic hepatitis without ascites, metabolic encephalopathy, respiratory failure, hypokalemia, severe protein-calorie malnutrition, and anxiety disorder. On 9/26/22 at 11:00 AM, an interview was conducted with resident 48. Resident 48 stated that she administered her own pain patches and menthol cream that were in her night stand. Resident 48 stated that she experienced pain and those helped with her pain. On 9/28/22 at 9:42 AM, a follow up interview was conducted with resident 48. Resident 48 stated that she had Salonpas patches and pain relief cream from a local store. Resident 48 stated she did not apply the patches very often. Resident 48 stated if she had a cramp or something then she used them. Resident 48 was observed to open the top drawer of her night stand. There was a box of Salonpas and pain relief cream observed in the night stand. An observation was made of Artificial tears eye drops on resident 48's over bed table. Resident 48 stated that she applied her eye drops and then gave them back to the nurse. Resident 48's medical record was reviewed on 9/28/22. There was no self administration assessment located in resident 48's medical record to determine if resident 48 was able to administer her own medications safely. There was no information on resident 48's care plans regarding self administration of medications. (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/28/22 at 9:25 AM, an interview was conducted with Registered Nurse (RN) 3. RN 3 stated residents should not have medications at the bedside. RN 3 stated if a resident wanted to administer medications then a waiver needed to be signed. RN 3 stated medication would be kept in the medication cart. RN 3 stated the nurse would write a note that the resident administered the medication. RN 3 stated the Director of Nursing (DON) took care of the waivers and then put them in the resident's medical record. RN 3 stated there were no residents with waivers. On 9/28/22 at 2:48 PM, an interview was conducted with the DON. The DON stated there should be an evaluation done to see if a resident was able to administer their own medications and then it should be care planned. The DON stated that medications were stored on a case by case basis. The DON stated some residents kept the medications in their night stands or in a lock box in the resident's room. The DON stated over the counter medications were treated the same as prescription medications. The DON stated the facility was unable to search resident belongings so staff would ask about medications. On 9/29/22 at 10:30 AM, a follow up interview was conducted with the DON. The DON stated resident 48 and resident 25 did not have an assessment to evaluate if the residents were able to self administer medications.

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	465129	A. Building B. Wing	10/03/2022

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30563 Based on interview and record review, it was determined, the facility did not ensure the resident's right to request, refuse, and/or discontinue treatment, and to formulate an advance directive. Specifically, for 1 out of 34 sampled resident, a resident did not have an advance directive accessible to the nursing staff. Resident identifier: 48. Findings included: Resident 48 was admitted to the facility on [DATE] with diagnoses which included Alcoholic hepatitis without ascites, metabolic encephalopathy, respiratory failure, hypokalemia, severe protein-calorie malnutrition, and anxiety disorder. Resident 48's medical record was reviewed on 9/26/22. There was no advance directive located in resident 48's medical record. On 9/28/22 at 9:44 AM, an interview was conducted with resident 48. Resident 48 stated that she had a Do Not Resuscitate (DNR) that she provided the facility when she was admitted . On 9/28/22 at 9:58 AM, an interview was conducted with Registered Nurse (RN) 3. RN 3 stated for a resident's code status, she would look at the resident's Physician Orders for Life Sustaining Treatment (POLST) form. RN 3 stated that the dashboard in the resident's medical record also listed the code status. RN 3 stated she was not aware of where the POLST form was located in the new electronic medical record. RN 3 stated that she would look at the dashboard in the event of an emergency and then would verify later with the POLST form. RN 3 stated some of the resident's rooms had red fishes on door that meant to not resuscitate. On 9/28/22 at 12:17 PM, an interview was conducted with the Director of Nursing (DON). The DON stated if a resident came to the facility with an advance directive than that advance directive was used by facility staff. The DON stated if the resident did not have an advance directive, then a POLST form was completed upon admission. The DON stated that the physician had to sign if the POLST was a DNR. The DON stated the resident was a full code until a DNR was signed by the physician. On 9/28/22 at 12:28 PM, an interview was conducted with RN 3. RN 3 stated that she was not aware of a POLST book at the nurse's station. The binder labeled POLST at the nurses station did not have a POLST form for resident 48. On 9/29/22 at 10:46 AM, an interview was conducted with the DON. The DON stated resident 48 completed a POLST form last night and resident 48 chose to be a full code. The DON stated she was unable to find a POLST.

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	465129	A. Building B. Wing	10/03/2022

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45470 Based on observation and interview, the facility did not provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. Specifically, the carpets in the facility had multiple stains and the couches were worn and had holes in the cushions. Findings included: On 9/27/22 at 10:15 AM, a walk through of the facility was conducted. The following observations were made; a. Multiple large stains were observed on the carpet between the 300 and 400 hallway. b. Multiple large stains were observed on the carpet in the 300 hallway near the dining room area. c. Multiple large stains were observed on the carpet outside of room [ROOM NUMBER]. d. Multiple large stains were observed on the carpet outside of room [ROOM NUMBER] and 408. e. Multiple large stains were observed on the carpet in the 200 hallway near the dining room. f. Multiple large stains were observed on the carpet in the 100 hallway. g. A couch in the lounge area in between the 300 and 400 hallway had multiple small tears in the cushion. h. The couches in the lounge area between the 300 and 400 hallway were darkened and worn in the seats and the armrests. On 10/3/22 at 9:15 AM, an interview with Certified Nursing Assistant (CNA) 2 was conducted. CNA 2 stated that the stains on the carpet have been there since she started working at the facility approximately five months ago. CNA 2 stated that the carpet occasionally got shampooed, but the stains always remained on the carpet. On 10/3/22 at 9:35 AM, an interview with the Housekeeping Supervisor (HS) was conducted. The HS stated that the couches get disinfected daily, and once a month the couches get a deep clean. The HS stated that the couches would get a deep clean if they become soiled for any reason. The HS stated that the couches were darkened and had tears because the couches were old, and need replaced. On 10/3/22 at 9:23 AM an interview with the Administrator (ADMIN) was conducted. The ADMIN stated that the facility was planning on a remodel which would include replacing the floors. The ADMIN stated that he was not sure when the remodel was going to happen.

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	465129	A. Building B. Wing	10/03/2022

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30563 Based on observation, interview, and record review it was determined, for 2 out of 34 sampled residents, that the resident did not have the right to voice grievances to the facility or other agencies or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. In addition, the facility did not maintain evidence demonstrating the results of all grievances for a period of no less than three years from the issuance of the grievance decision. Specifically, there were no grievances for a period of time during transition of staff into the Resident Advocate position. In addition, residents reported grievances that were not followed up. Resident identifiers: 16 and 29. Findings included: The grievance log was reviewed. There was a grievance dated 5/2/22, regarding call lights. There were two grievances dated 9/12/22, regarding call lights not being answered and meal cards not being followed. There were no grievances between 5/3/22 through 9/12/22. The Administrator provided Resident Council Minutes dated 4/5/22, 5/3/22, 6/7/22, 7/12/22, 8/2/22, and 9/12/22. The Resident Council Minutes dated 9/12/22, revealed long call light times and there was no follow-up documented. 1. Resident 29 was admitted to the facility on [DATE] with diagnoses which included low back pain, injury to left lower leg, hypothyroidism, edema, chronic pain, and nausea. An admission Minimum Data Set, dated dated dated [DATE], revealed resident 29 had a Brief Interview of Mental Status score of 15 which revealed resident 29 was cognitively intact. On 9/26/22 at 12:32 PM, an interview was conducted with resident 29. Resident 29 stated she was missing fifteen dollars and had reported to staff but no one had followed-up with her about it. On 10/3/22 at 10:30 AM, an interview was conducted with the Director of Nursing (DON). The DON stated there should be a grievance or complaint process. The DON stated that she heard about something with resident 29 a week ago. The DON stated it was something about being provided a lock box for her things. On 10/3/22 at 9:21 AM, an interview was conducted with the Administrator. The Administrator stated that his best guess was that the Resident Advocate (RA) was training the Business Office Manager (BOM) so there might have not been enough time to complete grievances. The Administrator stated that the Resident Council Minutes were used to address grievances between 5/3/22 and 9/12/22. On 10/3/22 at 10:04 AM, an interview was conducted with Certified Nursing Assistant (CNA) 2. CNA 2 stated if a resident reported missing items, then she looked for the missing item. CNA 2 stated if she was unable to find the item, then she notified the RA. CNA 2 stated that the RA then went through her process. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/3/22 at 12:12 PM, an interview was conducted with the RA. The RA stated she obtained grievance forms in care conference meeting, resident council, and through the staff. The RA stated residents had her phone extension so they could call her to tell her about any grievances they have. The RA stated recently staff got resident 29 a lock box because resident 29 was concerned her things were going missing. The RA stated resident 29 was provided a lock box for her own security. The RA stated she had not heard that resident 29 was missing fifteen dollars. The RA stated when staff gave resident 29 the lock box, resident 29 was educated on keeping funds in her room. The RA stated that the admission agreement stated that the facility was not responsible for missing items and that money should be stored in the personal funds account. The RA stated that the previous RA that was here left. The RA stated she was the BOM and had to train a new BOM before being trained to be the RA. The RA stated she trained the BOM for about a month and the Corporate Social Service Worker (CSSW) helped remotely daily and was at the facility once a week. The RA stated she was not sure who was handling grievances before she became the RA full time. The RA stated if she received staffing grievances so took them to the nursing leadership, who pulled call light reports, and educated staff on importance of answering a call light. The RA stated she had a few complaints regarding staffing when she transitioned into the RA position. On 10/3/22 at 12:21 PM, an interview was conducted with the CSSW. The CSSW stated the previous RA was at the facility until about June 2022. The CSSW stated that the current RA transitioned to the RA from being the BOM. The CSSW stated the prior BOM left after a couple months and the current RA had to train a new BOM. The CSSW stated she helped out at the facility when she could because she had other facilities to oversee. The CSSW stated she was not over the grievances, but if a resident stopped her facility staff would work on them. The CSSW stated she filled out one grievance during the time she was helping. The CSSW stated grievances were generated through, Interdisciplinary team meetings, resident council, residents knew where the RA's offices was, there were some forms at the nurses station, and there was a pocket to put the form in for the RA. The CSSW stated there were no grievances from resident 29. The CSSW stated that the RA told her that resident 29 called her phone the other day and asked for another pill from the nurse. The CSSW stated she did not know resident 29 very well but that she did not come out of her room. 2. Resident 16 was admitted to the facility on [DATE] with diagnoses which included cellulitis of left lower limb, severe protein-calorie malnutrition, lymphedema, anemia, and hypertension. On 10/3/22 at 9:49 AM, an observation was made of resident 16 talking to Physical Therapy Assistant (PTA) 1 and Occupational Therapist (OT) 1. Resident 16 stated the facility was so short staffed on Saturday night that a CNA came in and told him she did not have time to change him. Resident 16 stated a nurse came in later and he told the nurse that if he was not changed he would call the police. Resident 16 stated he told staff it was their choice on what he did. Resident 16 stated the CNA came in and changed him very quickly. Resident 16 stated he hated to be that kind of a guy but he had no other choice. Resident 16 stated he was looking at other facilities because of staffing. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465129	A. Building B. Wing	10/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Parkway Health Center	55 South Professional Way Payson, UT 84651

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/3/22 at 12:31 PM, an interview was conducted with PTA 1. PTA 1 stated she did not remember talking to resident 16. After being reminded of the conversation, PTA 1 stated that resident 16 stated there was one CNA and one nurse working. PTA 1 stated resident 16 was worried because he had to teach the CNA how to use the hoyer lift to transfer him. PTA 1 stated resident 16 said when it got to the point that he did not feel safe he would call the police. PTA 1 stated resident 16 said he needed to have a brief change and someone went in to change him but said they needed to come back. PTA 1 stated that resident 16 said the nurse came into his room and he told the nurse if he did not get changed he would call the police. PTA 1 stated she had not reported the information to management. PTA 1 stated she was planning on talking to the DON about it. On 10/3/22 at 12:31 PM, an interview was conducted with OT 1. OT 1 stated that resident 16 claimed that every time that he had a new CNA working with him, the CNA did not know how to transfer him. OT 1 stated if resident 16 was not in the exact right spot then he did not think the CNA knew what they were doing. OT 1 stated some of resident 16's complaints might be warranted. OT 1 stated resident 16 was very sensitive to any new staff. OT 1 stated there had been times when staffing was poor over the weekends and it feeds into the fact that it had not been fixed and might not be going away. OT 1 stated he usually talked to the RA, DON, and Administrator and the concerns were discussed in the morning meeting throughout the day.

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	465129	A. Building B. Wing	10/03/2022

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30563 Based on observation, interview, and record review it was determined, for 3 out of 34 sampled residents, the facility did not ensure that residents were free from abuse, neglect, misappropriation of resident property, and exploitation. Specifically, a Certified Nursing Assistant (CNA) was observed to verbally abuse a resident and two other residents reported the same CNA verbally abused them. In addition, the CNA was able to finish her shift with the residents. Resident identifiers: 16, 36, and 37. Findings included: A facility abuse investigation dated 9/15/22, revealed that resident 16, 36, and 37 alleged abuse from CNA 3. CNA 3 was identified as an agency CNA. The investigation revealed that Registered Nurse (RN) 7 reported that CNA 3 had verbally abused resident 16, 36, and 37. Resident 16 reported that after dinner he was waiting to be changed and when CNA 3 came into change him and pulled off his brief she said eww you smell like a pig and had a disgusted look on her face. Resident 37 was not interviewable but RN 7 reported, she witnessed an interaction between CNA 3 and resident 37. RN 7 indicated that when resident 37 moved his arms, CNA 3 screamed at the patient, don't hit me, I will hit you back, and then I am going to call the police, and you will spend the rest of your life in jail, and old people don't last in jail. Resident 36 reported that CNA 3 made some remarks to her like you are acting like a kid and playing in your poop and I will not change you unless you wear this type of brief. The Summary of Evidence revealed it was clear, given witness and resident statements that these allegations were true, even though CNA 3 denied ever saying any of those things. The Corrective Action was CNA 3 was removed from any scheduled shifts at the facility and was not allowed to pick up any future shifts. The residents were notified that CNA 3 would no longer work at the facility in the future. Based on the findings during the investigation, the facility substantiated the allegations of verbal abuse. 1. Resident 16 was admitted to the facility 6/3/21 with diagnoses which included cellulitis of left lower limb, severe protein-calorie malnutrition, lymphedema, anemia, and hypertension. Resident 16's medical record was reviewed on 9/29/22. An annual Minimum Data Set (MDS) assessment dated [DATE], revealed a Brief Interview of Mental Status (BIMS) score of 15 which indicated resident 16 was cognitively intact. The MDS further revealed that resident 16 required two plus person extensive assistance with toileting. (continued on next page)

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	465129	A. Building B. Wing	10/03/2022

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 9/28/22 at 11:20 AM, an interview was conducted with resident 16. Resident 16 stated CNA 3 had lost her license. Resident 16 stated that CNA 3 went into his room waiting to go to bed and his brief was not in great shape, but had not soaked through yet. Resident 16 stated it took the staff so long to change his brief that he had another accident and then he was even more wet. Resident 16 stated CNA 3 placed him in bed and took off his pants. Resident 16 stated that CNA 3 stated Eww you smell like a pig and something like I'm doing all I can to not vomit right now. Resident 16 stated another agency CNA laughed. Resident 16 stated he was silent for the rest of the brief change because he felt really low. Resident 16 stated staff had never made him feel bad about being changed or his smells. Resident 16 stated CNA 3 may have entered his room another time during her shift. Resident 16 stated RN 7 filled a complaint for him and the Resident Advocate (RA) had him give a statement. Resident 16 stated he had worked with CNA 3 prior to the incident and she was extremely rude. Resident 16 stated CNA 3 made him feel like she did not care. Resident 16 stated this was where people came to get help and hoped that people treated them with respect and dignity. 2. Resident 37 was admitted to the facility on [DATE] with diagnoses which included cerebral infarction, acute kidney failure, severe protein-calorie malnutrition, urinary tract infection, diabetes mellitus, anxiety disorder, and atherosclerotic heart disease. Resident 37's medical record was reviewed on 9/29/22. A quarterly MDS assessment dated [DATE], revealed a BIMS score of 3 which indicated resident 37 had severe cognitive deficit. On 9/28/22 at 11:45 AM, an observation was made of resident 37. Resident 37 was not interviewable. 3. Resident 36 was admitted to the facility on [DATE] with diagnoses which included, but not limited to, viral pneumonia, chronic respiratory failure with hypoxia, pulmonary hypertension, anemia, hyperkalemia, pain, and essential hypertension. Resident 36's medical record was reviewed on 9/29/22. A quarterly MDS assessment dated [DATE], revealed a BIMS score of 9 which indicated moderately impaired cognition. (continued on next page)

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	465129	A. Building B. Wing	10/03/2022

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/3/22 at 12:25 PM, an interview was conducted with resident 36. Resident 36 stated the incident with CNA 3 happened during shift change. Resident 36 stated that she had been dealing with diarrhea for a day or two prior to the incident. Resident 36 stated that CNA 3 asked resident 36 why she had pooped on the floor and if resident 36 had been playing in her poop again. Resident 36 stated that she was trying to clean herself up so there was not such a mess. Resident 36 stated that the wipes she was using were on the floor because she had missed the garbage can while trying to clean herself up. Resident 36 stated that she was in her right mind and did not play in her poop. Resident 36 stated that CNA 3 told resident 36 that she would not change resident 36 unless resident 36 put on a tab brief. Resident 36 stated that CNA 3 told resident 36 that CNA 3 did not like resident 36. Resident 36 stated that she wore a pull-up brief with an insert and she did not want to wear a tab brief. Resident 36 stated that CNA 3 told resident 36 that CNA 3 had to be at the facility until 10:30 PM, and CNA 3 was not coming back into resident 36's room. Resident 36 stated that CNA 3 might have come back to her room once after the incident. Resident 36 stated that she had reported the incident to the floor nurse. Resident 36 stated that a CNA from the other side of the facility took care of her the rest of the night. Resident 36 further stated that CNA 3 was rough cleaning her up and it hurt. Resident 36 stated that she felt abused by CNA 3. Resident 36 stated that the incident with CNA 3 happened on a Saturday or a Sunday and no one at the facility questioned her about the incident until Thursday of that week. Resident 36 stated that she had informed the Social Services Director that she was scared. Resident 36 stated that CNA 3 had been complaining about how long she had to be at the facility that night and CNA 3 looked filthy and ungroomed. On 9/28/22 at 12:28 PM, a phone interview was conducted with RN 7. RN 7 stated she was provided abuse training through her agency when she was hired in April 2022. RN 7 stated she was in the dining area by the medication cart and she heard screaming from resident 37's room. RN 7 stated she went into resident 37's room to see what was going on because resident 37 usually screamed but it was worse than usual. RN 7 stated there were two CNA's in the room and CNA 3 was yelling back at resident 37. RN 7 stated that resident 37 would not hit anyone even if he was yelling. RN 7 stated she heard CNA 3 say something like Don't hit me, I'll hit you back, and then I'm going to call the police, and you'll spend the rest of your life in jail and old people don't last in jail. RN 7 stated she stood there for a minute because she had never heard anything like that. RN 7 stated the other CNA in the room, was shocked and her face was bright red. RN 7 stated that the other CNA tried to console resident 37. RN 7 stated she texted her Agency regarding the incident the next day. RN 7 stated she did not report to anyone at the facility because she was not aware of who was in charge because management was always changing. RN 7 stated that CNA 3 finished her shift that night. RN 7 stated that she assessed resident 37 for bruising or anything that looked like physical abuse. RN 7 stated resident 37 did not have any signs of physical abuse. RN 7 stated her agency asked for her to email them what happened and was asked by her agency if it was okay that Adult Protective Services (APS) was contacted. RN 7 stated there were no staff that interviewed her or talked to her about the incident. RN 7 stated that CNA 3 continued to work the remainder of her shift that night. RN 7 stated that she was the medication pass nurse so she worked a half a shift and left early before CNA 3. RN 7 stated the next day resident 16 told her that he was very upset about having to wait to be changed. RN 7 stated that resident 16 told her that CNA 3 said to him Eww you smell like a pig when he was getting his brief changed. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 9/28/22 at 1:25 PM, an interview was conducted with the Director of Nursing (DON). The DON stated if she received an allegation of abuse, she reported it to APS, reported it to the State Survey Agency, made sure that the abuse coordinator (Administrator) was notified, reported to police, and ombudsman. The DON stated she would report to the State Survey Agency within two hours or 24 hours depending on the allegation. The DON stated the facility would start with their own internal investigation, talk to the resident about the occurrence, ask other residents in the near by locations to see if there were similar situations. The DON stated staff would be interviewed about what they witnessed or if they knew anything about the situation. The DON stated the RA and Administrator conducted interviews. The DON stated she did not know the details of the abuse investigation involving resident 16, 36, and 37. The DON stated she knew it was an agency staff member that made the allegation. The DON stated the staff member reported to her agency and the agency reported to APS. The DON stated that somehow the Administrator got the APS report number. The DON stated that the RA conducted interviews. The DON stated she was not sure who were interviewed. The DON stated the agency staff member told the Administrator what happened in a letter. The DON stated she was not sure of the findings of the investigation. The DON stated that the agency staff member who was accused of abuse was asked not to return to protect the residents. The DON stated the facility had an agreement that the agency would provide abuse training prior to sending a staff member to the facility. The DON stated the agency staff member should report abuse allegations to someone at the facility. The DON stated she did not have documentation of abuse education for agency staff but would contact the agency for their training. On 9/29/22 at 9:00 AM, an interview was conducted with the Human Resource Director (HRD). The HRD stated she did not check the CNA registry or obtain Direct Access Clearance System (DACS) screening for agency CNA's prior to working in the facility. The HRD stated that she checked the CNA registry and obtained DACS screening for CNA's that were employed at the facility. On 9/29/22 at 10:45 AM, a follow-up interview was conducted with the DON. The DON stated she contacted CNA 3's agency company for her abuse training. The DON stated she would ask about the CNA registry check and DACS screening. [Note: No additional information was provided.] (continued on next page)

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	465129	A. Building B. Wing	10/03/2022

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 9/29/22 at 11:36 AM, an interview was conducted with the RA and Corporate Social Service Worker. The RA stated that she had been working at the facility for about eight weeks as the RA. The RA stated if a resident notified her of abuse, then she would notify the DON and the Administrator. The RA stated a thorough investigation would be completed. The RA stated that interviews would be conducted to determine if abuse occurred. The RA stated that if there was abuse, then she would report to the State Survey Agency within two hours. The RA stated if there was no actual harm, like verbal abuse or misappropriation then she would report within 24 hours. The RA stated that resident 16 had a couple of allegations of abuse. The RA stated one of them was reported on 9/9/22. The RA stated resident 16 reported that he pushed his call light, was waiting to get changed, while waiting he had another incontinent episode. The RA stated resident 16 reported CNA 3 went in his room and changed him, when she pulled down his brief CNA 3 said Eww you smell like a pig. The RA stated that the DON and previous Administrator were aware, so they had already submitted the report to the State Survey Agency. The RA stated that she completed interviews with a couple other residents. The RA stated that resident 36 was interviewed. The RA stated that resident 36 told her that she had a bowel movement and she pushed the call light. The RA stated resident 36 stated she tried to clean herself up, tried to throw her wipes in the trash but missed. The RA stated that resident 36 said CNA 3 said why did you do that, that she was acting like a little kid, and asked why she made a mess. The RA stated that resident 36 told her she felt very belittled by it. The RA stated that she was not asked to do anything beyond the interviews with the residents. The facility Abuse- Prevention, Investigation and Reporting policy and procedure revised on 7/1/21, was reviewed and revealed the following: Purpose: 1. Educate employees to issues of abuse, neglect and exploitation. 2. To prevent abuse, neglect, and exploitation of resident. 3. TO ensure prompt reporting of actual or suspected abuse, neglect, or exploitation to the appropriate authorities. Policy: [Name of company] prohibits any abuse of resident from any source. This includes staff abuse, peer resident abuse, .[Name of company] seeks to promote the well being of its residents by providing a safe supportive environment. Every resident has the right to be free from verbal, sexual physical and mental abuse, corporal punishment and involuntary seclusion. Definitions: . VERBAL ABUSE: Means the use of oral, written, or gestured language that willfully includes degrading or derogatory terms to residents or their families, or within their hearing distance, regardless of their age, ability to comprehend, or their disability. Threats of harm (continued on next page)

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	465129	A. Building B. Wing	10/03/2022

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Saying things to frighten a resident Making fun of a resident Saying something that would make the resident uncomfortable, or others uncomfortable. .MENTAL ABUSE: Includes but is not limited to humiliation, harassment, . PROCEDURE: 1. Screening: All potential employees will be screened as part of the application process. A Criminal Background Investigation will be completed on every new employee. Reference checks on new employees will include a minimum of two references, and should include contact with current, and past employers. Licensure (where applicable) will be verified to ensure licensed employees are in good standing. If anything in the employees screening process indicates a history of abuse or misappropriation of property, the individual will be referred to administrator. Where applicable by State law, yearly Criminal Background Investigations will be completed on all staff at the time the facility applies for a license renewal. Continued employment is contingent upon Criminal Background investigation. 2. Training: All employees will be trained at hire and annually thereafter as to what would constitute abuse, neglect and misappropriation of resident property. 3. Prevention: New employees will be trained to identify potential signs and symptoms of abuse including behavior changes and injuries of unknown origin. Annual training to employees will be given to identify incidents or allegations, which need investigated. Residents that are assessed to be at risk will have appropriate monitoring and behavioral approaches developed as part of their Care Plan. (continued on next page)

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	465129	A. Building B. Wing	10/03/2022

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Prospective residents will be screened to determine if there is a history of abusive behavior. If it is determined that the facility can adequately meet the needs of a potential resident who has a history of abusive behavior, a care plan will be developed to include approaches to prevent the potential resident from engaging in abusive behavior. A drug free work place is enforced. A background check will be performed on all direct care volunteers. Residents will be educated at admit and during Resident Council meetings of their right to be free from abuse. 4. Identification: Any employee, consultant, or any other person affiliated with the operation of this facility that has reason to believe that a resident has been subject to abuse, neglect, or exploitation, shall immediately notify the facility Administrator, Director of Nursing, or their designee, so that appropriate action may be taken. Obtain the name of any witnesses Complete an Incident Report immediately which shall include a complete description of the circumstances and details of the incident relating to the abuse, neglect, or exploitation. The descriptions should include names of all persons involved, time, place, and all other pertinent information and evidence related to the occurrence in question. 'A person who is required to report suspected abuse, emotional or psychological abuse, neglect or exploitation of a resident and who willfully fails to do so is guilty of a class B misdemeanor.' 5. Investigation: . Other Suspected Abuse Incidents: ? Any person who suspects that abuse, neglect or misappropriation of property may have occurred, will immediately report the alleged violation to the attending nurse who immediately notifies the Administrator, Director of Nursing, or patient Advocate. The Administrator or his designee will initiate an investigative process as soon as possible, but not to exceed 24 hours after discovery of the incident. This investigation may consist of: a. Review of completed incident report, and any supporting documents. b. Interviews with the person or persons reporting the incident. c. Interview with any witnesses to the incident. d. Review of the resident's medical record. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	e. Interview with staff members (on all shifts) having contact with the resident during the period of the alleged incident. f. Interview with the resident's roommates, family members, and visitors who might have knowledge of the resident. g. Interviews with other residents who have been cared for by the staff member in suspicion. h. A review of all the circumstances around the incident. General Investigative Procedures: Witness reports shall be documented and signed by the witness . 6. Protection: Following an allegation of abuse, the facility will immediately implement increased monitoring of any residents deemed to be at risk for further abuse. If the alleged perpetrator is a resident, necessary revisions will be implemented in order to ensure the safety of other residents. This may include change of roommates, close monitoring, etc. If the complaint alleges abuse be a staff member, that staff member will be suspended or removed from direct patient care (whichever is appropriate to protect the resident) until an investigation had been completed There will be no reprisal to staff for reporting abuse allegations. 7. Reporting: All alleged violations and all substantiated incidents, injuries of unknown source will be reported to the appropriate State Survey Agency as immediately as possible with the results of its findings within five (5) working days. The Director of Nursing or designee will be responsible to notify the resident's attending physician. The Administrator, Director of Nursing, Resident Advocate, or designee will be responsible to notify the resident and his/her, legal representative. Any actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff will be reported by [Name of company] to the: (continued on next page)

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	465129	A. Building B. Wing	10/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	a. State nurse aide registry. b. Appropriate State Licensing Agency If appropriate: Notify the Ombudsman Adult Protective Services (APS) or law enforcement must be notified for: a. alleged violations b. injuries of unknown origin when abuse is suspected All substantiated abuse reports will be forwarded to the [Name of company] Management Office, Chief Operating Officer (COO). If it is determined that abuse may have occurred, the Policy Committee will review the finding and determine if any changes in current policies and procedures are required to prevent further potential for abuse. 33215

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	465129	A. Building B. Wing	10/03/2022

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30563 Based on observation, interview, and record review it was determined, for 3 out of 34 sampled residents, in response to an allegation of abuse, neglect, exploitation, or mistreatment the facility did not ensure that all alleged violations were reported immediately, but not later than two hours after the allegation was made, if the events that caused the allegation involve abuse or resulted in serious bodily injury. Specifically, the State Survey Agency was not notified until five days after an abuse allegation was made. Resident identifiers: 16, 36, and 37. Findings included: A facility abuse investigation dated 9/15/22, revealed that resident 16, 36, and 37 alleged abuse from Certified Nursing Assistant (CNA) 3. CNA 3 was identified as an agency CNA. The investigation revealed that Registered Nurse (RN) 7 reported that CNA 3 had verbally abused resident 16, 36, and 37. Resident 16 reported that after dinner he was waiting to be changed and when CNA 3 came into change him and pulled off his brief she said eww you smell like a pig and had a disgusted look on her face. Resident 37 was not interviewable but RN 7 reported, she witnessed an interaction between CNA 3 and resident 37. RN 7 indicated that when resident 37 moved his arms, CNA 3 screamed at the patient, don't hit me, I will hit you back, and then I am going to call the police, and you will spend the rest of your life in jail, and old people don't last in jail. Resident 36 reported that CNA 3 made some remarks to her like you are acting like a kid and playing in your poop and I will not change you unless you wear this type of brief. The Summary of Evidence revealed it was clear, given witness and resident statements that these allegations were true, even though CNA 3 denied ever saying any of those things. The Corrective Action summary revealed that the facility was notified on 9/9/22, from the staffing agency. In addition, CNA 3 was removed from any scheduled shifts at the facility and was not allowed to pick up any future shifts. The residents were notified that CNA 3 would no longer work at the facility in the future. Based on the findings during the investigation, the facility substantiated the allegations of verbal abuse. A letter from RN 7 stated that there were two incidents that took place on 9/4/22. 1. Resident 16 was admitted to the facility 6/3/21 with diagnoses which included cellulitis of left lower limb, severe protein-calorie malnutrition, lymphedema, anemia, and hypertension. Resident 16's medical record was reviewed on 9/29/22. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465129	A. Building B. Wing	10/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Parkway Health Center	55 South Professional Way Payson, UT 84651

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An annual Minimum Data Set (MDS) assessment dated [DATE], revealed a Brief Interview of Mental Status (BIMS) score of 15 which indicated resident 16 was cognitively intact. The MDS assessment further revealed that resident 16 required two plus person extensive assistance with toileting. On 9/28/22 at 11:20 AM, an interview was conducted with resident 16. Resident 16 stated CNA 3 had lost her license. Resident 16 stated that CNA 3 went into his room waiting to go to bed and his brief was not in great shape, but had not soaked through yet. Resident 16 stated it took the staff so long to change his brief that he had another accident and then he was even more wet. Resident 16 stated CNA 3 placed him in bed and took off his pants. Resident 16 stated that CNA 3 stated Eww you smell like a pig and something like I'm doing all I can do to not vomit right now. Resident 16 stated another agency CNA laughed. Resident 16 stated he was silent for the rest of the brief change because he felt really low. Resident 16 stated staff had never made him feel bad about being changed or his smells. Resident 16 stated CNA 3 may have entered his room another time during her shift. Resident 16 stated RN 7 filled a complaint for him and the Resident Advocate (RA) had him give a statement. Resident 16 stated he had worked with CNA 3 prior to the incident and she was extremely rude. Resident 16 stated CNA 3 made him feel like she did not care. Resident 16 stated this was where people came to get help and hoped that people treated them with respect and dignity. 2. Resident 37 was admitted to the facility on [DATE] with diagnoses which included cerebral infarction, acute kidney failure, severe protein-calorie malnutrition, urinary tract infection, diabetes mellitus, anxiety disorder, and atherosclerotic heart disease. Resident 37's medical record was reviewed on 9/29/22. A quarterly MDS assessment dated [DATE], revealed a BIMS score of 3 which indicated resident 37 had severe cognitive deficit. On 9/28/22 at 11:45 AM, an observation was made of resident 37. Resident 37 was not interviewable. 3. Resident 36 was admitted to the facility on [DATE] with diagnoses which included, but not limited to, viral pneumonia, chronic respiratory failure with hypoxia, pulmonary hypertension, anemia, hyperkalemia, pain, and essential hypertension. Resident 36's medical record was reviewed on 9/29/22. A quarterly MDS assessment dated [DATE], revealed resident 36 had a BIMS score of 9 which indicated moderately impaired cognition. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/3/22 at 12:25 PM, an interview was conducted with resident 36. Resident 36 stated the incident with CNA 3 happened during shift change. Resident 36 stated that she had been dealing with diarrhea for a day or two prior to the incident. Resident 36 stated that CNA 3 asked resident 36 why she had pooped on the floor and if resident 36 had been playing in her poop again. Resident 36 stated that she was trying to clean herself up so there was not such a mess. Resident 36 stated that the wipes she was using were on the floor because she had missed the garbage can while trying to clean herself up. Resident 36 stated that she was in her right mind and did not play in her poop. Resident 36 stated that CNA 3 told resident 36 that she would not change resident 36 unless resident 36 put on a tab brief. Resident 36 stated that CNA 3 told resident 36 that CNA 3 did not like resident 36. Resident 36 stated that she wore a pull-up brief with an insert and she did not want to wear a tab brief. Resident 36 stated that CNA 3 told resident 36 that CNA 3 had to be at the facility until 10:30 PM, and CNA 3 was not coming back into resident 36's room. Resident 36 stated that CNA 3 might have come back to her room once after the incident. Resident 36 stated that she had reported the incident to the floor nurse. Resident 36 stated that a CNA from the other side of the facility took care of her the rest of the night. Resident 36 further stated that CNA 3 was rough cleaning her up and it hurt. Resident 36 stated that she felt abused by CNA 3. Resident 36 stated that the incident with CNA 3 happened on a Saturday or a Sunday and no one at the facility questioned her about the incident until Thursday of that week. Resident 36 stated that she had informed the Social Services Director that she was scared. Resident 36 stated that CNA 3 had been complaining about how long she had to be at the facility that night and CNA 3 looked filthy and ungroomed. On 9/28/22 at 12:28 PM, a phone interview was conducted with RN 7. RN 7 stated she was provided abuse training through her agency when she was hired in April 2022. RN 7 stated she was in the dining area by the medication cart and she heard screaming from resident 37's room. RN 7 stated she went into resident 37's room to see what was going on because resident 37 usually screamed but it was worse than usual. RN 7 stated there were two CNA's in the room and CNA 3 was yelling back at resident 37. RN 7 stated that resident 37 would not hit anyone even if he was yelling. RN 7 stated she heard CNA 3 say something like Don't hit me, I'll hit you back, and then I'm going to call the police, and you'll spend the rest of your life in jail and old people don't last in jail. RN 7 stated she stood there for a minute because she had never heard anything like that. RN 7 stated the other CNA in the room, was shocked and her face was bright red. RN 7 stated that the other CNA tried to console resident 37. RN 7 stated she texted her Agency regarding the incident the next day. RN 7 stated she did not report to anyone at the facility because she was not aware of who was in charge because management was always changing. RN 7 stated that CNA 3 finished her shift that night. RN 7 stated that she assessed resident 37 for bruising or anything that looked like physical abuse. RN 7 stated he did not have any signs of physical abuse. RN 7 stated her agency asked for her to email them what happened and was asked by her agency if it was okay that Adult Protective Services (APS) was contacted. RN 7 stated there were no staff that interviewed her or talked to her about the incident. RN 7 stated that CNA 3 continued to work the remainder of her shift that night. RN 7 stated that she was the medication pass nurse so she worked a half a shift and left early before CNA 3. RN 7 stated the next day resident 16 told her that he was very upset about having to wait to be changed. RN 7 stated that resident 16 told her CNA 3 said to him Eww you smell like a pig when he was getting his brief changed. (continued on next page)

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	465129	A. Building B. Wing	10/03/2022

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 9/28/22 at 1:25 PM, an interview was conducted with the Director of Nursing (DON). The DON stated if she received an allegation of abuse then, she reported it to APS, reported it to the State Survey Agency, made sure that the abuse coordinator (Administrator) was notified, reported to police and the ombudsman. The DON stated she would report to the State Survey Agency within two hours or 24 hours depending on the allegation. The DON stated the facility would start with their our own internal investigation, talk to the resident about the occurrence, ask other residents in the near by locations to see if there were similar situations. The DON stated staff would be interviewed about what they witnessed or if they knew anything about the situation. The DON stated the RA and Administrator conducted interviews. The DON stated she did not know the details of the abuse investigation involving resident 16, 36, and 37. The DON stated she knew it was an agency staff member that made the allegation. The DON stated the staff member reported to her agency and the agency reported to APS. The DON stated that somehow the Administrator got the APS report number. The DON stated that the RA conducted interviews. The DON stated she was not sure who were interviewed. The DON stated the agency staff member told the Administrator what happened in a letter. The DON stated she was not sure of the findings of the investigation. The DON stated that the agency staff member who was accused of abuse was asked not to return to protect the residents. The DON stated the facility had an agreement that the agency would provide abuse training prior to sending a staff member to the facility. The DON stated the agency staff member should report abuse allegations to someone at the facility. The DON stated she did not have documentation of abuse education for agency staff but would contact the agency for their training. On 9/29/22 at 9:00 AM, an interview was conducted with the Human Resource Director (HRD). The HRD stated she did not check the CNA registry or obtain Direct Access Clearance System (DACS) screening for agency CNA's prior to working in the facility. The HRD stated that she checked the CNA registry and obtained DACS screening for CNA's that were employed at the facility. On 9/29/22 at 10:45 AM, a follow-up interview was conducted with the DON. The DON stated she contacted CNA 3's agency company for her abuse training. The DON stated she would ask about the CNA registry check and DACS screening. [Note: No additional information was provided.] (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 9/29/22 at 11:36 AM, an interview was conducted with the RA and Corporate Social Service Worker. The RA stated that she had been working at the facility for about eight weeks as the RA. The RA stated if a resident notified her of abuse, then she would notify the DON and the Administrator. The RA stated a thorough investigation would be completed. The RA stated that interviews would be conducted to determine if abuse occurred. The RA stated that if there was abuse, then she would report to the State Survey Agency within two hours. The RA stated if there was no actual harm, like verbal abuse or misappropriation then she would report within 24 hours. The RA stated that resident 16 had a couple of allegations of abuse. The RA stated one of them was reported on 9/9/22. The RA stated resident 16 reported that he pushed his call light, was waiting to get changed, while waiting he had another incontinent episode. The RA stated resident 16 reported CNA 3 went in his room and changed him, when she pulled down his brief CNA 3 said Eww you smell like a pig. The RA stated that the DON and previous Administrator were aware, so they had already submitted the report to the State Survey Agency. The RA stated that she completed interviews with a couple other residents. The RA stated that resident 36 was interviewed. The RA stated that resident 36 told her that she had a bowel movement and she pushed the call light. The RA stated resident 36 stated she tried to clean herself up, tried to throw her wipes in the trash but missed. The RA stated that resident 36 said CNA 3 said why did you do that, that she was acting like a little kid, and asked why she made a mess. The RA stated that resident 36 told her she felt very belittled by it. The RA stated that she was not asked to do anything beyond the interviews with the residents. The facility Abuse- Prevention, Investigation and Reporting policy and procedure revised on 7/1/21, was reviewed and revealed the following: Purpose: 1. Educate employees to issues of abuse, neglect and exploitation. 2. To prevent abuse, neglect, and exploitation of resident. 3. TO ensure prompt reporting of actual or suspected abuse, neglect, or exploitation to the appropriate authorities. Policy: [Name of company] prohibits any abuse of resident from any source. This includes staff abuse, peer resident abuse, .[Name of company] seeks to promote the well being of its residents by providing a safe supportive environment. Every resident has the right to be free from verbal, sexual physical and mental abuse, corporal punishment and involuntary seclusion. Definitions: . VERBAL ABUSE: Means the use of oral, written, or gestured language that willfully includes degrading or derogatory terms to residents or their families, or within their hearing distance, regardless of their age, ability to comprehend, or their disability. Threats of harm (continued on next page)

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	465129	A. Building B. Wing	10/03/2022

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Saying things to frighten a resident Making fun of a resident Saying something that would make the resident uncomfortable, or others uncomfortable. .MENTAL ABUSE: Includes but is not limited to humiliation, harassment, . 7. Reporting: All alleged violations and all substantiated incidents, injuries of unknown source will be reported to the appropriate State Survey Agency as immediately as possible with the results of its findings within five (5) working days. The Director of Nursing or designee will be responsible to notify the resident's attending physician. The Administrator, Director of Nursing, Resident Advocate, or designee will be responsible to notify the resident and his/her, legal representative. Any actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff will be reported by [Name of company] to the: a. State nurse aide registry. b. Appropriate State Licensing Agency If appropriate: Notify the Ombudsman Adult Protective Services (APS) or law enforcement must be notified for: a. alleged violations b. injuries of unknown origin when abuse is suspected All substantiated abuse reports will be forwarded to the [Name of company] Management Office, Chief Operating Officer (COO). If it is determined that abuse may have occurred, the Policy Committee will review the finding and determine if any changes in current policies and procedures are required to prevent further potential for abuse.

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	465129	A. Building B. Wing	10/03/2022

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Not transfer or discharge a resident without an adequate reason; and must provide documentation and convey specific information when a resident is transferred or discharged. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33215 Based on interview and record review it was determined, the facility did not ensure that a transfer or discharge was documented in the resident's medical record and that appropriate information was communicated to the receiving health care institution or provider. Specifically, for 2 out of 34 sampled residents, residents that were transferred to the hospital did not have a transfer assessment or a reason for the transfer documented in the medical record. In addition, no documentation was found in the resident's medical record to indicate the receiving provider was provided contact information of the practitioner responsible for the resident's care, resident representative contact information, advance directive information, all special instructions for care, a discharge summary, and any other documentation necessary for a safe and effective transition of care. Resident identifiers: 44 and 45. Findings included: 1. Resident 44 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included, but not limited to, acute kidney failure, diabetes mellitus type 2, anxiety disorder, essential hypertension, and urinary tract infection. Resident 44's medical record was reviewed on 9/28/22. On 8/6/22 at 5:37 PM, a Nursing progress note documented Pt [Patient] was found calling out for people that weren't there in her room around 4pm today. I checked her vitals [vital signs]. Her oxygen was at 60, RR [respiratory rate] 18 Temp [temperature] 98 bp [blood pressure] 122/88. I put oxygen on her and it wouldn't get to 90 until I put it to about 5 Liters. I informed NP [Nurse Practitioner] and Dr [Doctor] of the facility via tiger text. There was no response back on the matter. Kept her on oxygen because when I take it off, she dips back down to below 90. She stopped calling out to unseen others after I put the oxygen on. Its almost end of shift, she is at 93 and has oxygen on. I will give this information in report at the end of shift. Lungs sounds clear in all lobes. Pt stated that even though I was giving her, her blood sugar, that she didn't feel like taking her self administered insulin. Her bs [blood sugar] around 5pm was 497. She gave me permission to give her 10 units of fast acting insulin. On 8/6/22 at 8:37 PM, resident 44 had a documented oxygen saturation of 91%. [Note: There were no oxygen saturations documented for resident 44 on 8/7/22.] On 8/8/22 at 3:01 AM, a Nursing progress note documented 8/7/22 2200 [10:00 PM]-This Nurse called non emergency transport to send Pt to [name of hospital removed] to be evaluated d/t [due to] change in condition .such as: increase in oxygen therapy, is a feeder, edematous, and change in mentation. 2220 [10:20 PM]-EMS [Emergency Medical Services] arrived to facility 2228 [10:28 PM]-Pt left facility on Stretcher Family notified and MD [Medical Director] 8/8/22 0217 [2:17 AM]- UPDATE- admitted to ICU [Intensive Care Unit] No documentation could be found of a transfer assessment or reason for the transfer. No documentation was found of the medical records that were provided to the receiving provider. (continued on next page)

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	465129	A. Building B. Wing	10/03/2022

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/27/22 at 3:12 PM, an interview was conducted with the Director of Nursing (DON). The DON stated if a resident needed to be transferred out of the facility staff should complete a change of condition transfer form. On 10/3/22 at approximately 12:40 PM, an interview was conducted with Registered Nurse (RN) 1. RN 1 stated that she was an agency nurse and it was her first day working at the facility. RN 1 stated she had no knowledge regarding the circumstances of resident 44's hospitalization . On 10/3/22 at 12:58 PM, an interview was conducted with the Assistant Director of Nursing (ADON). The ADON stated that resident 44 was diagnosed at the hospital with a urinary tract infection. The ADON stated when resident 44 was readmitted to the facility resident 44 had a new diagnoses of renal failure and was put on dialysis. The ADON stated that resident 44 was possibly sent out to the hospital due to a change in mental status. On 10/3/22 at 1:59 PM, an interview was conducted with the DON. The DON stated she had no knowledge regarding the circumstances of resident 44's hospitalization . 38031 2. Resident 45 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included major depressive disorder, adult failure to thrive, abdominal pain, hydroureter, anemia, opioid dependence, and anxiety disorder. On 9/26/22 at 10:47 AM, an interview was conducted with resident 45. Resident 45 stated she had a seizure and was transferred to the hospital. On 6/10/22 at 1:30 AM, the hospital History & Physical documented the resident had a history of major depressive disorder with psychotic symptoms with altered mental status. The report documented, The patient is unable to provide a history, and comes with very sparse records. The report documented that resident 45 reported having difficulty finding words and was staring off into space. The resident then had a tonic clonic seizure with tongue biting in the emergency department, and was treated with Keppra and Ativan. A computerized tomography brain scan without contrast revealed no acute intracranial abnormality. Review of resident 45's progress notes revealed the following: a. On 6/10/22 at 12:34 AM, the nurse note documented, Med [medication] pass nurse sent out resident to [name of hospital omitted] around 2230 [10:30 PM], and then med pass nurse left facility around 2300 [11:00 PM]. Before end of shift, will follow up with [name of hospital omitted] for update. b. On 6/10/22 at 2:01 AM, the nurse note documented, Called [name of hospital omitted], nurse reported that resident was admitted to Med/Surg [medical/surgical] floor with seizure diagnosis. No other information was received. No documentation could be found of a transfer assessment or reason for the transfer. No documentation was found of the medical records that were provided to the receiving provider. (continued on next page)

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	465129	A. Building B. Wing	10/03/2022

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/3/22 at 9:06 AM, an interview was conducted with RN 6. RN 6 stated that she was an agency nurse and was not familiar with the facility protocol when a resident had a change in condition. RN 6 stated that she had worked yesterday, had a resident who had fallen and was on a anticoagulant. RN 6 stated that she wanted to transfer the resident to the emergency department (ED). RN 6 stated that she attempted to notify the provider, left a voicemail, and never heard a response back from the NP. RN 6 stated that she called the DON and was told to complete a fall report on the incident and send the resident to the hospital. RN 6 stated that she would have liked to document the incident in a progress note, but she did not know how to use the electronic medical records. RN 6 stated that she was not provided any instruction on how to use the electronic medical records and she had not used this system prior to this facility. RN 6 stated that she was not provided any orientation to the facility and was only given the DON's phone number and login information for the computer. RN 6 stated that the previous nurse gave her the medical records website to log on for the Medication Administration Record (MAR) RN 6 stated that she was able to navigate the system, but it took her longer to educate herself on the system. RN 6 stated that she was not able to navigate beyond the MAR. RN 6 stated she would have liked to know how to find the patient's diagnosis and plan of care. On 10/3/22 at 9:16 AM, an interview was conducted with the ADON. The ADON stated that with a change in condition the staff were to contact the provider to explain the change in condition. The ADON stated that if they did not hear back from the provider they would call the family or ask the resident what they would like to do. The ADON stated that the staff were to notify the DON, medical provider, and family if a resident was transferred to the ED. The ADON stated that the nurse on shift was to call the ED and provide a verbal report and should send a copy of the resident's face sheet with demographics, medication list, any progress notes explaining the incident or situation and a copy of the resident's Physician Ordered for Life-Sustaining Treatment. The ADON stated that the nurse should document in the progress notes the incident and need for a transfer to the hospital. The ADON stated that with the previous medical records system they had an e-interact transfer form assessment to fill out. The ADON stated that the nurse may not document what paperwork was sent to the receiving provider in the progress notes, but that it would most likely be located on the daily nurse report sheet. The ADON stated that the information that was sent to the receiving provider was not documented in the resident's medical record. The ADON stated that the agency binder, located at the nurse's station, would have information on the procedure for a resident change in condition and transfers. The ADON reviewed resident 45's medical record and stated that there was no transfer form for the resident's transfer to the hospital on 6/10/22. The ADON stated that the e-interact transfer form should have been completed by the nurse who was sending the resident to the ED. The ADON stated that resident 45's progress notes did not document what had occurred at the facility that initiated a transfer to the ED. The ADON stated that it looked like the staff needed some education on this process. On 10/3/22 at approximately 9:25 AM, an observation was made of the agency binder located at the nurse's station on the 300 and 400 hallways. The agency binder did not have any documentation or instructions on what staff should complete during the transfer process.

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	465129	A. Building B. Wing	10/03/2022

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F 0638 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Assure that each resident's assessment is updated at least once every 3 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45470 Based on interview and record review, the facility did not assess residents using the quarterly review instrument specified by the State and approved by Centers for Medicare and Medicaid Services not less frequently than once every three months. Specifically, for 3 out of 34 sampled residents, quarterly Minimum Data Set (MDS) assessments were not completed every three months. In addition, quarterly MDS assessments were not completed no later than 14 days after the assessment reference date (ARD). Resident identifiers: 3, 4, and 7. Findings included: 1. Resident 3 was admitted to the facility on [DATE] with diagnoses which included Alzheimer's disease, atherosclerotic heart disease, chronic obstructive pulmonary disease, essential hypertension, type 2 diabetes mellitus, and major depressive disorder. Resident 3's quarterly MDS assessment was reviewed, and it was revealed that the ARD target date for completion of the quarterly MDS assessment was 8/12/22. The quarterly MDS assessment which was due on 8/12/22, was not started and the ARD date was 32 days overdue. 2. Resident 4 was admitted to the facility on [DATE] with diagnoses which included fracture of superior rim of left pubis, glaucoma, age-related osteoporosis, and mood disorder due to known physiological condition with depressive features. Resident 4's quarterly MDS assessment was reviewed, and it was revealed that the ARD target date for completion of the quarterly MDS assessment was 8/13/22. The quarterly MDS assessment which was due on 8/13/22, was not started and the ARD date was 31 days overdue. 3. Resident 7 was admitted to the facility on [DATE] with diagnoses which included type 2 diabetes mellitus, repeated falls, muscle weakness, unspecified dementia, weakness, essential hypertension, major depressive disorder, sleep apnea, atrial fibrillation, insomnia, idiopathic gout, and hyperlipidemia. Resident 7's quarterly MDS assessment was reviewed, and it was revealed that the ARD target date for completion of the quarterly MDS assessment was 8/28/22. The quarterly MDS assessment was not completed, and the status was marked as In Progress. On 9/28/22 at 11:25 AM, an interview with the MDS Coordinator (MDSC) was conducted. The MDSC stated that he was currently in training for the MDSC position, and the Assistant Director of Nursing was responsible for the MDS assessments before the MDSC started. The MDSC explained that a report was generated each day and it indicated which MDS assessments were due. The MDSC was able to see that resident 3, resident 4, and resident 7 had late quarterly MDS assessments. On 9/28/22 at 11:45 AM, an interview with the Corporate MDS Coordinator (CMDSC) was conducted. The CMDSC confirmed that resident 3, resident 4, and resident 7 had late quarterly MDS assessments.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465129	A. Building B. Wing	10/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Parkway Health Center	55 South Professional Way Payson, UT 84651

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45470 Based on interview and record review, it was determined that for 3 out of 34 sampled residents, the facility assessments did not accurately reflect the resident's status. Specifically, two resident's Minimum Data Set (MDS) assessments were coded incorrectly by indicating that the two residents were on an anticoagulant when the residents were not, and a resident who was receiving dialysis was not coded as receiving dialysis. Resident identifier: 8, 36, and 44. Findings include: 1. Resident 8 was admitted to the facility on [DATE] with diagnoses which included dementia, hypokalemia, type 2 diabetes mellitus, chronic pain syndrome, essential hypertension, hypothyroidism, and muscle weakness. On 9/27/22, resident 8's medical record was reviewed. Resident 8's most recent MDS assessment from 6/29/22, reported that resident 8 was receiving an anticoagulant. Resident 8's current and recent discharged physician ordered medications were reviewed, and it was revealed that resident 8 was not receiving an anticoagulant. 2. Resident 36 was admitted to the facility on [DATE] with diagnoses which included viral pneumonia, chronic respiratory failure with hypoxia, pulmonary hypertension, anemia, and hyperkalemia. On 9/27/22, resident 36's medical record was reviewed. Resident 36's most recent MDS assessment from 7/29/22, reported that resident 36 was receiving an anticoagulant. Resident 36's current and recent discharged physician ordered medications were reviewed, and it was revealed that resident 36 was not receiving an anticoagulant. On 9/28/22 at 11:25 AM, an interview with the MDS Coordinator (MDSC) was conducted. The MDSC stated that he was currently in training for the MDSC position, and the Assistant Director of Nursing (ADON) was responsible for the MDS's before the MDSC started. The MDSC was able to see that resident 8 and resident 36 were not receiving anticoagulants and confirmed that the MDS assessments were incorrect. On 9/28/22 at 11:45 AM, an interview with the Corporate MDS Coordinator (CMDSC) was conducted. The CMDSC confirmed that resident 8 and resident 36 had incorrect MDS assessments regarding anticoagulant usage. 33215 (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465129	A. Building B. Wing	10/03/2022

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. Resident 44 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included, but not limited to, acute kidney failure, diabetes mellitus type 2, anxiety disorder, essential hypertension, and urinary tract infection. On 9/26/22 at approximately 10:00 AM, an interview was conducted with the Director of Nursing (DON). The DON stated that resident 44 would be leaving the facility soon for dialysis. The resident Matrix For Providers was provided by the facility upon entrance and was reviewed. Resident 44 was not checked for receiving Dialysis services. Resident 44's medical record was reviewed on 9/28/22. An admission MDS assessment dated [DATE], did not document that resident 44 was receiving dialysis services while not a resident and while a resident. On 8/23/22, the Discharge Summary from the hospital documented that resident 44 had end stage renal disease. A temporary dialysis catheter was placed on admission and a tunneled dialysis catheter was placed on 8/15/22. Resident 44 continues on scheduled hemodialysis per Nephrology. The Discharge Instructions included, but not limited to, hemodialysis per Nephrology orders. Tunneled hemodialysis catheter care per Nephrology. Discharge to Skilled Nursing Facility. On 8/25/22 at 1:50 PM, a Nurse Practitioner progress note documented . SUBJECTIVE: [Name of resident 44 removed] is seen today as a readmit. She has a medical history significant for T2DM [type 2 diabetes mellitus] on insulin, CKD [chronic kidney disease], HTN [hypertension], HLD [hyperlipidemia], and multiple wounds. She was sent to [name of hospital removed] with nausea and decreased by mouthintake [sic] where she was found to have hyperkalemia and a GFR [glomerular filtration rate]< [less than] 10. She was started on dialysis, is followed by Nephrology. On 9/3/22 at 8:33 PM, a Dietary progress note documented INITIAL [Name of resident 44 removed] is here with AKF [acute kidney failure], UTI [urinary tract infection], hyperlipidemia, DM2 [diabetes mellitus type 2], and anxiety. Diet order is Renal,CCHO [Consistent Carbohydrate Diet]/Regular consistency. Meal intakes are good with mostly 76-100%. She is going to dialysis 3x [times]/week at [name of dialysis center removed]. On 9/29/22 at 8:12 AM, an interview was conducted with resident 44. Resident 44 stated that she could not remember when she started dialysis. On 9/29/22 at 11:45 AM, an interview was conducted with the ADON. The ADON stated that he was the MDS coordinator prior to 9/27/22. The ADON stated that central intake would provide him with a quick base on new admissions that included a history and physical from the hospital, physical therapy notes, and doctor notes. The ADON stated when resident 44 was at the facility prior to the most recent admission resident 44 was not on dialysis. The ADON stated that he missed the dialysis on the MDS assessment when resident 44 was readmitted on [DATE].

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	465129	A. Building B. Wing	10/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Parkway Health Center	55 South Professional Way Payson, UT 84651

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38031 Based on observation, interview, and record review it was determined, for 8 out of 34 sampled residents, that the facility did not develop and implement a baseline care plan for each resident that included instructions needed to provide effective and person-centered care to meet professional standards of quality care. Specifically, residents did not have a baseline care plan developed within 48 hours of admission, and the baseline care plan did not include the minimum healthcare information necessary to properly care for the residents. Resident identifiers: 8, 20, 23, 29, 44, 45, 49, and 155. Findings included: 1. Resident 8 was admitted to the facility on [DATE] with diagnoses which included dementia without behavioral disturbance, hypokalemia, type 2 diabetes mellitus, chronic pain syndrome, hypertension, hypothyroidism, urinary tract infection, muscle weakness, abnormalities of gait and mobility, and hyperlipidemia. Review of the facility's New Admission Checklist revealed that baseline care plans should be initiated for admission on any specific care plans needed such as infection, wound, skin, falls, pain, activities of daily living function, and nutrition. On 9/26/22, resident 8's medical record was reviewed. Review of resident 8's care plans revealed no documentation of a baseline care plan. 2. Resident 20 was admitted to the facility on [DATE] with diagnoses which included tinea cruris, repeated falls, disorder of kidney and ureter, hyperkalemia, hypertension, type 2 diabetes mellitus, diabetic mellitus with foot ulcer, diabetic neuropathy, multiple rib fractures, and osteomyelitis. On 9/27/22, resident 20's medical record was reviewed. On 7/6/22, resident 20's care plan had the following focus areas initiated: a. Required skilled nursing at this time with and would like to return to the community when able. b. At risk for psychosocial well being issues secondary to Coronavirus Disease-2019 (COVID-19) pandemic. c. At risk for psychosocial well being issues secondary to need for skilled nursing care. d. Uses tobacco products, cigarettes, independently and safe with use. (continued on next page)

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	465129	A. Building B. Wing	10/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Parkway Health Center	55 South Professional Way Payson, UT 84651

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 9/28/22 at 11:30 AM, an interview was conducted with the Director of Nursing (DON) and the Corporate Minimum Data Set Coordinator (CMDSC). The DON confirmed that there was no care plan for diabetes, and stated that she would have liked to see a care plan that addressed resident 20's diabetes. The CMDSC stated that diabetes should have been addressed on the baseline care plan because it was an admitting diagnosis. The DON stated that the Assistant Director of Nursing was the previous Minimum Data Set (MDS) coordinator and was responsible for completing the baseline and comprehensive care plan. The DON stated that the baseline care plan should be completed within 48 hours after admission. The DON stated that the baseline care plan should include pain, fall, nutrition, and skin. The DON stated that she had a check list that addressed the focus areas that needed to be included in a baseline care plan. The DON stated that she wanted the staff to use the check list, but she did not know if it was implemented. The DON stated that it would be done now. 3. Resident 23 was admitted to the facility on [DATE] with diagnoses which included fracture of right femur, congestive heart failure, gastro-esophageal reflux disease, deep vein thrombosis of lower extremity, insomnia, hypothyroidism, alcohol dependence, major depressive disorder, and post-traumatic stress disorder. On 9/26/22 at 12:22 PM, an interview was conducted with resident 23. Resident 23 stated that she had pain in her femur and feet. Resident 23 stated that the pain was a 10/10, on a scale of 1 to 10. Resident 23 stated that the pain in her feet was due to neuropathy and was so painful that she could hardly touch her feet to the ground. On 9/27/22, resident 23's medical record was reviewed. On 4/3/22, resident 23's care plan had the following focus areas initiated: a. At risk for adjustment/psychosocial well being issues secondary to need for skilled nursing care. b. At risk for psychosocial well being issues related to COVID-19 pandemic. c. Required skilled nursing at this time with and would like to return to the community when able. 4. Resident 45 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included major depressive disorder, adult failure to thrive, abdominal pain, hydroureter, anemia, opioid dependence, and anxiety disorder. On 9/27/22, resident 45's medical record was reviewed. Review of resident 45's care plans revealed no documentation of a baseline care plan. 30563 5. Resident 29 was admitted to the facility on [DATE] with diagnoses which included low back pain, injury to left lower leg, hypothyroidism, edema, chronic pain, and nausea. Resident 29's medical record was on 9/28/22. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465129	A. Building B. Wing	10/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An admission MDS dated [DATE], revealed that resident 29 had a Brief Interview of Mental Status of 15 which indicated cognitively intact. Resident 29 was occasionally incontinent of bowel and bladder and was not on a toileting program. The MDS further revealed resident 29 required two plus person extensive assistance with toileting. The MDS further revealed resident 29 frequently had pain which limited her day-to-day activities and made it hard for her to sleep at night. There was no baseline care plan developed for urinary incontinence or pain. 45470 6. Resident 155 was admitted to the facility on [DATE] with diagnoses which included unspecified fracture of left femur, hyperkalemia, nonrheumatic aortic stenosis, and acute on chronic combined systolic and diastolic heart failure. On 9/27/22, resident 155's medical record was reviewed. Resident 155's care plan was reviewed, and it revealed that there was no baseline care plan related to falls. On 9/7/22 at 5:19 PM, a Nursing Progress Note revealed, Res [Resident] had fall, called to shower by CNA [Certified Nursing Assistant] res was lying on back. Res said he slipped. Fall was not witnessed. Res denied pain at this time. Assessed, no apparent injury at time. Neuro [neurological] checks started and were wnl [within normal limits] . On 9/11/22 at 3:33 PM, a progress note revealed that resident 155 was here with a L [Left] hip fx [fracture] after a fall. On 9/27/22 at 3:18 PM, an interview with the DON was conducted. The DON stated that if a resident came to the facility with recent falls, the resident should have a baseline care plan for falls. 33215 7. Resident 44 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included, but not limited to, acute kidney failure, diabetes mellitus type 2, anxiety disorder, essential hypertension, and urinary tract infection. On 9/26/22 at approximately 10:00 AM, an interview was conducted with the DON. The DON stated that resident 44 would be leaving the facility soon for dialysis. The resident Matrix For Providers was provided by the facility upon entrance and was reviewed. Resident 44 was not checked for receiving Dialysis services. Resident 44's medical record was reviewed on 9/28/22. (continued on next page)

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	465129	A. Building B. Wing	10/03/2022

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 8/23/22, the Discharge Summary from the hospital documented that resident 44 had end stage renal disease. A temporary dialysis catheter was placed on admission and a tunneled dialysis catheter was placed on 8/15/22. Resident 44 continues on scheduled hemodialysis per Nephrology. The Discharge Instructions included, but not limited to, hemodialysis per Nephrology orders. Tunneled hemodialysis catheter care per Nephrology. Discharge to Skilled Nursing Facility. Review of resident 44's care plan revealed that the baseline care plan was initiated on 8/23/22, for the care areas of diabetes, infection, respiratory, pain, falls, activities of daily living function and rehabilitation potential, skin integrity, psychotropic drug use, discharge plan return to the community, psychosocial well-being, and adjustment to placement. [Note: The facility did not develop and implement a baseline care plan for resident 44 that included dialysis services.] On 9/28/22 at 11:27 AM, an interview was conducted with Registered Nurse (RN) 2. RN 2 stated the floor nurses did not create care plans. RN 2 stated the DON and the administration would complete their individual assessments of the resident. On 9/29/22 at 10:33 AM, an interview was conducted with the DON. The DON stated if a resident was receiving dialysis there should be a physician's order. The DON stated the care plan should include items for transportation, and anything specific to the resident that they would want outside of medication. 8. Resident 49 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included, but not limited to, hemorrhage of anus and rectum, dementia, history of falling, type 2 diabetes mellitus with hyperglycemia, displaced fracture of second cervical vertebra, major depressive disorder, systolic congestive heart failure, secondary hypertension, and edema. On 9/26/22 at 12:04 PM, an interview was conducted with resident 49. Resident 49 stated that he had fallen three times since he was admitted to the facility. Resident 49 was unable to give any details regarding the three falls and resident 49 could not remember if he had any injuries with the three falls. Resident 49 stated that he had fallen at home and was in a back brace when he admitted to the facility. Resident 49 stated that recently he was taken out of the back brace and given a neck brace. Resident 49 was observed to have a neck brace on. Resident 49's medical record was reviewed on 9/27/22. On 6/30/22, the Discharge Summary from the hospital documented that resident 49 had discharge diagnoses which included, but not limited to, C (cervical vertebrae) 1 and C2 cervical fractures. Review of resident 49's care plan revealed that the facility did not develop and implement a baseline care plan. On 7/6/22 at 12:59 PM, a Social Services Note documented Admit Note: [Name of resident 49 removed] is an 80 YO [year old] widower who admitted from [name of hospital removed] on 6/30 [22] after sustaining an unwitnessed fall resulting in a C1-2 fx. (continued on next page)

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	465129	A. Building B. Wing	10/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Parkway Health Center	55 South Professional Way Payson, UT 84651

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 9/27/22 at 3:12 PM, an interview was conducted with the DON. The DON stated that the MDS coordinator would help get baseline care plans started. The DON stated that baseline care plans were basic care plans. The DON stated the comprehensive assessment Care Area Assessment summary areas should be care planned by the MDS coordinator. The DON stated the nursing team should be looking at resident change of condition or something specific to the resident that needed to be care planned. The DON stated that the administrative nursing team would complete the care plan updates. The DON stated if a resident came from the hospital with a fall she would expect the fall to be care planned.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465129	A. Building B. Wing	10/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Parkway Health Center	55 South Professional Way Payson, UT 84651

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33215 Based on observation, interview, and record review, it was determined, the facility did not develop and implement a comprehensive person-centered care plan for each resident. Specifically, for 7 out of 34 sampled resident, residents that had care areas trigger on the Minimum Data Set (MDS) Care Area Assessment (CAA) Summary did not have care plans developed and implemented in a timely manner. In addition, residents with identified concerns did not have care plans developed and implemented in a timely manner. Resident identifiers: 8, 20, 23, 29, 45, 49, and 53. Findings included: 1. Resident 49 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included, but not limited to, hemorrhage of anus and rectum, dementia, history of falling, type 2 diabetes mellitus with hyperglycemia, displaced fracture of second cervical vertebra, major depressive disorder, systolic congestive heart failure, secondary hypertension, and edema. On 9/26/22 at 12:04 PM, an interview was conducted with resident 49. Resident 49 stated that he had fallen three times since he was admitted to the facility. Resident 49 was unable to give any details regarding the three falls and resident 49 could not remember if he had any injuries with the three falls. Resident 49 stated that he had fallen at home and was in a back brace when he admitted to the facility. Resident 49 stated that recently he was taken out of the back brace and given a neck brace. Resident 49 was observed to have a neck brace on. Resident 49's medical record was reviewed on 9/27/22. The MDS CAA Summary dated 7/13/22, documented a Care Area Triggered for falls. In addition, the CAA Summary documented that falls were addressed in the care plan. [Note: A fall care plan was not created until 9/22/22.] On 7/29/22 at 2:21 AM, a Nurses Note documented Patient had an injury fall this shift at 0130 [1:30 AM], assisted to the fall by CNA [Certified Nursing Assistant]. CNA notified this Nurse. Pt [Patient] states he lost his balance. Denies pain at this time. Offered medication. Skin tear on right elbow (1cm [centimeter] X [by] 1xcm) and abrasion on right knee (3.5cm X 2cm). New injuries cleansed with wound cleanser, pat dry, and bacitracin applied. MD [Medical Director] Notified. [Note: The MDS CAA Summary dated 7/13/22, documented a Care Area Triggered for falls. A fall care plan was not created until 9/22/22.] On 9/1/22 at 8:45 PM, a Nursing progress note documented Patient fell on his back while attempting to get off the toilet. The fall was unwitnessed. Patient has a skin tear R [right] wrist. His neuro [neurological] check are normal and vitals [vital signs] are at baseline. Physician and family has been contacted. Patient is complaining of back pain but is refusing to get checked at the hospital. [Note: The MDS CAA Summary dated 7/13/22, documented a Care Area Triggered for falls. A fall care plan was not created until 9/22/22.] (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465129	A. Building B. Wing	10/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Parkway Health Center	55 South Professional Way Payson, UT 84651

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 9/5/22 at 10:26 PM, a Nursing note documented Resident had an assisted fall at 2200 [10:00 PM]. CNA was with resident in the bathroom. Resident was transferring to the toilet. CNA had already pulled wheelchair away. Resident had decided to sit down, not on the toilet. CNA caught resident and helped resident to the floor. 2 cnas and nurse helped resident get back into bed using hoyer lift. Resident did not hit head nor any other parts of his body. Resident is resting in bed. Vitals wnl [within normal limits]. [Note: The MDS CAA Summary dated 7/13/22, documented a Care Area Triggered for falls. A fall care plan was not created until 9/22/22.] A care plan Problem created on 9/22/22, documented Category: Falls [name of resident 49 removed is at risk for falls secondary to Weakness. A care plan Goal created on 9/22/22, documented Long Term Goal Target Date: 12/22/2022 [Name of resident 49 removed] will have no untreated injuries r/t [related to] falls, through next review. The care plan interventions created on 9/22/22, included: a. One on one activities evaluation and treatments if appropriate. b. Assist resident 49 with visual needs and visual appliance application and removal, as needed. c. Encourage the use of the call light. d. Evaluate the need to pace activities and plan rest periods, as tolerated. e. Keep room free of clutter and tripping hazards. f. Low bed without mat. g. Non-skid socks on at all times, as tolerated. h. Resident 49 had been educated on the call light function and use. A care plan Problem edited on 9/26/22, documented a Problem start date of 9/5/22. Category: Falls [Name of resident 49 removed] had an actual fall 9/1/22 and 9/5/22. A care plan Goal created on 9/26/22, documented Long Term Goal Target Date: 12/05/2022 [Name of resident 49 removed] will have no unaddressed complication or injury r/t fall through next review. The care plan interventions created on 9/26/22, documented an Approach start date of 9/5/22. The interventions included: a. Encourage resident 49 to use call light for assistance. b. Lowered to floor: continue plan of care with staff assistance with cares and toileting. On 9/27/22 at 3:12 PM, an interview was conducted with the Director of Nursing (DON). The DON stated that the MDS coordinator would help get baseline care plans started. The DON stated that baseline care plans were basic care plans. The DON stated the comprehensive assessment CAA Summary areas should be care planned by MDS coordinator. The DON stated the nursing team should be looking at resident change of condition or something specific to the resident that needed to be care planned. The DON stated that the administrative nursing team would complete the care plan updates. The DON stated if a resident came from the hospital with a fall she would expect the fall to be care planned. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465129	A. Building B. Wing	10/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Parkway Health Center	55 South Professional Way Payson, UT 84651

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	38031 2. Resident 8 was admitted to the facility on [DATE] with diagnoses which included dementia without behavioral disturbance, hypokalemia, type 2 diabetes mellitus, chronic pain syndrome, hypertension, hypothyroidism, urinary tract infection, muscle weakness, abnormalities of gait and mobility, and hyperlipidemia. Review of the facility's New Admission Checklist revealed that baseline care plans should be initiated for admission on any specific care plans needed such as infection, wound, skin, falls, pain, activities of daily living (ADL) function, and nutrition. On 9/26/22, resident 8's medical record was reviewed. On 6/16/22, an admission MDS assessment was completed. The CAA Summary triggered care plans for cognitive loss/dementia, ADL functional/rehabilitation potential, urinary incontinence and indwelling catheter, falls, pressure ulcer/injury, pain, and return to community referral. Review of resident 8's care plans revealed the following: a. On 9/27/22, a care plan for cognitive Loss/dementia, was created. The problem start date documented 9/27/22. It should be noted that there was no care plan developed for cognitive loss prior to 9/27/22, even though it was identified on the CAA Summary on 6/16/22. b. On 9/27/22, a care plan for tobacco use was edited. The problem start date documented 8/15/22. It should be noted that there was no care plan developed for tobacco use prior to 9/27/22. c. On 9/26/22, a care plan for infection was edited. The problem start date documented 6/9/22. It should be noted that there was no care plan developed for infection prior to 9/26/22, even though a urinary tract infection was identified upon admission. d. On 9/26/22, a care plan for pain was edited. The problem start date documented 6/9/22. It should be noted that there was no care plan developed for pain prior to 9/26/22, even though it was identified on the CAA on 6/16/22. e. On 9/26/22, a care plan for falls was edited. The problem start date documented 6/9/22. It should be noted that there was no care plan developed for falls prior to 9/26/22, even though it was identified on the CAA on 6/16/22. f. On 9/26/22, a care plan for ADL functional/rehabilitation was edited. The problem start date documented 6/9/22. It should be noted that there was no care plan developed for ADLs prior to 9/26/22, even though it was identified on the CAA on 6/16/22. On 9/29/22 at 11:06 AM, an interview was conducted with the DON. The DON stated that she was not aware if resident 8 had a history of falls. The DON stated that if resident 8 had a history of falls the care plan interventions would be specific for at risk for falls. The DON stated that she was not aware of any interventions to prevent accidents or wandering, but she would expect to see a care plan specific to wandering if interventions were identified and needed. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465129	A. Building B. Wing	10/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Parkway Health Center	55 South Professional Way Payson, UT 84651

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	[Cross-reference F689] 3. Resident 20 was admitted to the facility on [DATE] with diagnoses which included tinea cruris, repeated falls, disorder of kidney and ureter, hyperkalemia, hypertension, type 2 diabetes mellitus, diabetic mellitus with foot ulcer, diabetic neuropathy, multiple rib fractures, and osteomyelitis. On 9/27/22, resident 20's medical record was reviewed. On 4/25/22, an admission MDS assessment was completed. The CAA Summary triggered care plans for cognitive loss/dementia, ADL functional/rehabilitation potential, psychosocial well-being, and falls. Review of resident 20's care plans revealed the following: a. On 7/6/22, a care plan for required skilled nursing but would like to return to the community was initiated. b. On 7/6/22, a care plan for at risk for psychosocial well-being issues secondary to need for skilled nursing care was initiated. c. On 7/6/22, a care plan for used tobacco products was initiated. d. On 7/12/22, a care plan for wounds on left heel and amputation of left big toe was initiated. It should be noted that the care plan did not have any interventions documented. e. On 7/29/22, a care plan for alteration in thought process was initiated. It should be noted that no care plans were developed for ADL functional/rehabilitation potential and falls as identified on the CAA Summary. Additionally, no care plans were developed that addressed resident 20's diabetes, insulin, and nutrition. On 9/28/22 at 11:30 AM, an interview was conducted with the DON and the Corporate Minimum Data Set Coordinator (CMDSC). The DON confirmed that there was no care plan for diabetes and stated that she would have liked to see a care plan that addressed resident 20's diabetes. The CMDSC stated that diabetes should have been addressed on the baseline care plan because it was an admitting diagnosis. The DON stated that the Assistant Director of Nursing was the previous MDS coordinator and was responsible for completing the baseline and comprehensive care plans. [Cross-reference F745] 4. Resident 23 was admitted to the facility on [DATE] with diagnoses which included fracture of right femur, congestive heart failure, gastro-esophageal reflux disease, deep vein thrombosis of lower extremity, insomnia, hypothyroidism, alcohol dependence, major depressive disorder, and post-traumatic stress disorder (PTSD). On 9/26/22 at 12:22 PM, an interview was conducted with resident 23. Resident 23 stated that she had pain in her femur and feet. Resident 23 stated that the pain was a 10/10, on a scale of 1 to 10. Resident 23 stated that the pain in her feet was due to neuropathy and was so painful that she could hardly touch her feet to the ground. (continued on next page)

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	465129	A. Building B. Wing	10/03/2022

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 9/27/22, resident 23's medical record was reviewed. On 4/8/22, an admission MDS assessment was completed. The CAA Summary triggered care plans for delirium, cognitive loss/dementia, ADL functional/rehabilitation potential, urinary incontinence and indwelling catheter, falls, pain, and return to community referral. Review of resident 23's care plans revealed the following: a. On 6/3/22, a care plan for alteration in thought process manifested by moderate cognitive impairment was initiated. It should be noted that the care area was identified on the CAA Summary on 4/8/22. b. On 9/29/22, a care plan for substance abuse was created. The problem start date documented 8/1/22. It should be noted that there was no care plan developed for substance abuse prior to 9/29/22, even though alcohol dependence was identified upon admission on 4/2/22. c. On 9/29/22, a care plan for trauma was created. The problem start date documented 9/29/22. It should be noted that there was no care plan developed for trauma prior to 9/29/22, even though PTSD was identified upon admission on 4/2/22. d. On 9/29/22, a care plan for Preadmission Screening and Resident Review (PASRR) Level II was developed. The problem start date documented 9/29/22. It should be noted that there was no care plan developed for mental health diagnosis of major depressive disorder prior to 9/29/22, even though it was identified upon admission on 4/2/22. e. On 9/26/22, a care plan for pain was created. The problem start date documented 8/1/22. It should be noted that there was no care plan developed for pain prior to 8/1/22, even though it was identified on the CAA Summary on 4/8/22. f. On 9/26/22, a care plan for falls was created. The problem start date documented 8/1/22. It should be noted that there was no care plan developed for falls prior to 8/1/22, even though it was identified on the CAA Summary on 4/8/22. g. On 9/26/22, a care plan for ADL function was created. The problem start date documented 8/1/22. It should be noted that there was no care plan developed for ADLs prior to 8/1/22, even though it was identified on the CAA Summary on 4/8/22. 5. Resident 45 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included major depressive disorder, adult failure to thrive, abdominal pain, hydroureter, anemia, opioid dependence, and anxiety disorder. On 9/27/22, resident 45's medical record was reviewed. On 5/9/22, an admission MDS assessment was completed. The CAA Summary triggered care plans for cognitive loss/dementia, ADL functional/rehabilitation potential, urinary incontinence and indwelling catheter, psychosocial well-being, behavioral symptoms, falls, nutritional status, psychotropic drug use, pain, and return to community referral. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465129	A. Building B. Wing	10/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Parkway Health Center	55 South Professional Way Payson, UT 84651

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of resident 45's care plans revealed the following: a. On 9/26/22, a care plan for mood state was created. The problem start date documented 8/10/22. It should be noted that there was no care plan developed for mood prior to 8/10/22, even though major depressive disorder was identified upon admission on 5/3/22. b. On 9/26/22, a care plan for psychosocial well-being was created. The problem start date documented 8/1/22. It should be noted that there was no care plan developed for psychosocial well-being prior to 8/1/22, even though it was identified on the CAA Summary on 5/9/22. c. On 9/26/22, a care plan for behavioral symptoms was created. The problem start date documented 8/23/22. It should be noted that there was no care plan developed for behavioral symptoms prior to 8/23/22, even though it was identified on the CAA Summary on 5/9/22. d. On 9/26/22, a care plan for substance abuse was created. The problem start date documented 8/1/22, but opioid dependence was an admitting diagnosis on 5/3/22. It should be noted that there was no care plan developed for substance abuse prior to 8/1/22, even though opioid dependence was identified upon admission on 5/3/22. e. On 9/26/22, a care plan for PASRR Level II was created. The problem start date documented 8/1/22. It should be noted that there was no care plan developed for PASRR Level II prior to 9/29/22, even though major depressive disorder was identified upon admission on 5/3/22. f. On 9/26/22, a care plan for pain was created. The problem start date documented 8/1/22. It should be noted that there was no care plan developed for pain prior to 8/1/22, even though it was identified on the CAA Summary on 5/9/22. g. On 9/26/22, a care plan for nutritional status was created. The problem start date documented 8/1/22. It should be noted that there was no care plan developed for nutritional status prior to 8/1/22, even though it was identified on the CAA Summary on 5/9/22. h. On 9/26/22, a care plan for falls was created. The problem start date documented 8/1/22. It should be noted that there was no care plan developed for falls prior to 8/1/22, even though it was identified on the CAA Summary on 5/9/22. i. On 9/26/22, a care plan for ADL functional/rehabilitation was created. The problem start date documented 8/1/22. It should be noted that there was no care plan developed for ADLs prior to 8/1/22, even though it was identified on the CAA Summary on 5/9/22. j. On 9/26/22, a care plan for psychotropic drug use was created. The problem start date documented 8/1/22. It should be noted that there was no care plan developed for psychotropic drug use prior to 8/1/22, even though it was identified on the CAA Summary on 5/9/22. k. On 9/23/22, a care plan for discharge plan was created. The problem start date documented 9/23/22. It should be noted that there was no care plan developed for discharge planning prior to 9/23/22, even though it was identified on the CAA Summary on 5/9/22. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465129	A. Building B. Wing	10/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Parkway Health Center	55 South Professional Way Payson, UT 84651

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 9/27/22 at 2:40 PM, an interview was conducted with the DON. The DON stated that the process for developing care plans was that the MDS coordinator initiated baseline care plans and developed the comprehensive care plans from the CAA Summary. The DON stated that the nursing team should be looking at any change in conditions or anything specific that needed to be added to the care plan. The DON stated that medication changes or new therapies should be updated in the care plan. The DON stated that the nursing administration (DON, Assistant Director of Nursing, or MDS coordinator) should be updating the nursing care plans. The DON stated that other departments could care plan a condition also. The DON stated that any care refusals could be care planned. The DON stated that with refusals of care if there was a pattern identified they would talk to the Social Service Worker, have an Interdisciplinary Team (IDT) meeting and then care plan the refusals. The DON stated that if the resident was admitted from the hospital after a fall she would expect there to be a care plan for falls. 30563 6. Resident 29 was admitted to the facility on [DATE] with diagnoses which included low back pain, injury to left lower leg, hypothyroidism, edema, chronic pain, and nausea. Resident 29's medical record was on 9/28/22. An admission MDS assessment dated [DATE] revealed that resident 29 had a Brief Interview of Mental Status (BIMS) of 15 which indicated cognitively intact. Resident 29 was occasionally incontinent of bowel and bladder and was not on a toileting program. The MDS further revealed resident 29 required two plus person extensive assistance with toileting. The MDS CAA section revealed that resident 29 had urinary incontinence and it was addressed in a care plan. There was no care plan regarding urinary incontinence. 7. Resident 53 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included surgical aftercare following surgery, muscle weakness, lack of coordination, diabetes mellitus, sleep apnea, and generalized anxiety. On 9/26/22 at 2:33 PM, an interview was conducted with resident 53. Resident 53 stated he was transferring from wheelchair to bed and his ankle gave out and fell to the ground. Resident 53 stated his left shoulder always hurts but it hurt more since the fall. Resident 53 stated he was waiting for staff but staff did not come. Resident 53 stated he waited for 15 to 20 minutes and was tired from returning from a doctors appointment so he transferred himself. Resident 53 stated it took 20 to 30 minutes for someone to come and he did not want to wait. Resident 53's medical record was reviewed on 9/29/22. A quarterly MDS assessment dated [DATE], revealed resident 53 had a BIMS score of 14 which indicated he was cognitively intact. The MDS revealed the resident 53 required extensive assistance with two plus person physical assistance. The MDS revealed resident 53 had not had a fall in the last month, the last 2 to 6 months, or since admission. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465129	A. Building B. Wing	10/03/2022

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A care plan dated 5/10/19, and revised on 10/5/21, revealed resident 53 was at risk for fall related to impaired mobility, morbid obesity, and weakness. The goal was the resident would be free of falls through the review date. Approaches included anticipate and meet the resident's needs; call light within reach; resident needs prompt response to all requests for assistance; educate what to do if a fall occurs; and review information on past falls and attempt to determine cause of fall. An approach dated 9/22/20, revealed change position slowly to reduce change of hypotensive episodes. An updated fall care plan with a problem start date of 8/1/22, and created on 9/19/22, revealed that resident 53 was at risk for falls secondary to limited mobility and weakness. The goal was resident 53 would have no untreated injuries related to falls through next review. The approaches included encourage the use of call light and keep room free of clutter and tripping hazards. Progress notes revealed the following entries: a. On 6/3/22 at 12:20 PM, (Incident Report) Three CNA's were trying to reposition the patient in bed around 11am. [CNA name] and [CNA name] where pulling the patient in one direction and the agency CNA was pulling the patient in another. During the transition, I was told by [CNA name] that he fell off of the bed. I went in and assessed him. He didn't have any skin tares (sic) or abnormalities. He was oriented times four. He said his left hip hurts when he moves. He said it was an achy muscle pain. I checked it out and there was no bruise present at the time. I informed the other agency nurse working on his hall to continue to check on him by the hour even though I was told that he didn't hit his head. I notified [Nurse Practitioner's name] via tiger text and havent heard a response back as of yet. b. On 6/3/22 at 12:24 PM, CNA and 300 hall nurse reported that patient fell while transferring from his w/c [wheelchair] to his bed. Pt returned back from the appointment and got helped by CNA to his bed and slid down on his buttocks to the ground. physical assessment completed that no changes of cognitively, no skin issues noted without redness or bruise, no changes ROM [range of motion], but pt c/o [complains of] pain 6 out of 10 to left hip, scheduled norco 2 tablets given. notified 300 hall nurse about the assessment including pain and she will notify to NP [Nurse Practitioner]today, will continue to monitor any changes. c. On 7/29/22 at 6:57 PM, Note Text: Pt had Dr [doctor] appt [appointment] today., after returning CNA was getting him into bed via hoyer and pt slipped out of chair. Pt did not report any pain from the fall and did not hit head. Has no new pain from the witness fall and bs [blood sugar] & vitals are normal for pt post fall. Event report was made and signed. There were no incident reports for 6/3/22. There was a incident report completed for the fall on 7/29/22 at 5:53 PM. The report revealed resident 53 had a witnessed fall. Resident 53 slipped out of chair onto the floor onto his buttocks. The immediate action taken was nurse and additional two CNA's assisted patient back into bed with a hoyer lift. No issues and patient reported to be fine. Vitals were obtained and all were normal. There were no interventions developed after the fall on the incident report. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465129	A. Building B. Wing	10/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Parkway Health Center	55 South Professional Way Payson, UT 84651

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/3/22 at 11:37 AM, an interview was conducted with the Assistant Director of Nursing (ADON). The ADON stated if a resident fell , nurses completed a risk management report, assessed the resident, obtained vital signs, assessed for injuries, then started a neurological check sheet, contact the DON, physician, and family. The ADON stated once the fall was reported to the physician, the staff would send the resident to the hospital if there was a major injury. The ADON stated if it was a minor fall then the staff would complete neurological checks, a change of condition, progress note, and the risk management report. The ADON stated that agency staff were made aware at shift change about resident falls. The ADON stated there was also a binder at the nurses station for agency staff members but mostly information was provided from the nurse to nurse report. The ADON stated the management team completed an Interdisciplinary Team (IDT) meeting with the family, nursing team, social services, and therapy. The ADON stated the IDT team looked for fall trends and then referred to the Restorative Nursing Assistant program or therapy. The ADON stated new interventions were care planned. The ADON stated that resident 53 had a new care plan dated 8/1/22, in the new electronic medical record. The ADON observed the previous care plans and stated there were no interventions after the two falls on 6/3/22. The ADON stated for the fall on 7/29/22, the CNA was transferring resident 53 to his wheelchair when his legs gave out. The ADON stated resident 53 usually used the sit to stand lift and not a hoyer lift for transfers. The ADON stated the CNA could have used the hoyer if resident 53 was to weak to stand up on his own. The ADON stated according to the incident report resident 53 slid out of his chair and onto the floor. The ADON stated that they used a hoyer to get him off the floor and into bed. [It should be noted the nursing progress note on 7/29/22 revealed .after returning CNA was getting him into bed via hoyer and pt slipped out of chair.] On 10/3/22 at 11:26 AM, an interview was conducted with CNA 9. CNA 9 stated there was a CNA chart that had which residents fell and which residents were a high fall risk. CNA 9 stated the residents had signs inside their rooms and it was in the electronic charting system. CNA 9 stated she had no idea how Agency staff knew a residents transfer status or if the resident was a fall risk. CNA 9 stated Agency staff had a binder but she did not know what was in the binder. CNA 9 stated resident 53 required one person assistance with transfers, bed mobility, and showering. CNA 9 stated there was no reason that three people would be providing bed mobility.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465129	A. Building B. Wing	10/03/2022

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33215 Based on observation, interview, and record review, it was determined, the facility did not provide the necessary care and services to ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that such diminution was unavoidable. Specifically, for 5 out of 34 sampled residents, residents did not receive the bathing assistance they required and showers were missed. In addition, a resident with dirty fingernails did not receive the assistance they required to clean their fingernails. Resident identifier: 8, 22, 25, 47, and 53. Findings included: 1. Resident 22 was admitted to the facility on [DATE] with diagnoses which included, but not limited to, nontraumatic intracerebral hemorrhage, hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, type 2 diabetes mellitus, essential hypertension, muscle weakness, and chronic pain syndrome. On 9/26/22 at 10:31 AM, an interview was conducted with resident 22. Resident 22 stated that her shower days were every Tuesday, Thursday, and Saturday. This surveyor observed a sign in resident 22's room with the posted shower days. Resident 22 stated that sometimes she did not get showered due to there not being enough staff. Resident 22's medical record was reviewed on 9/27/22. An admission Minimum Data Set (MDS) assessment dated [DATE], documented that resident 22 required physical help in part of the bathing activity by two persons physical assistance. Resident 22's shower sheets were reviewed and the following showers were documented: a. On 7/11/22, a shower was provided. b. On 7/23/22, a shower was provided. [Note: Resident 22 went 11 days without a shower.] c. On 7/30/22, a shower was provided. [Note: Resident 22 went 6 days without a shower.] d. On 8/6/22, the shower sheet provided was blank. e. On 8/9/22, a shower was provided. [Note: Resident 22 went 9 days without a shower.] f. On 9/7/22, a shower was provided. [Note: Resident 22 went 28 days without a shower.] g. On 9/15/22, a shower was provided. [Note: Resident 22 went 7 days without a shower.] h. On 9/27/22, a shower was provided. [Note: Resident 22 went 11 days without a shower.] (continued on next page)

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	465129	A. Building B. Wing	10/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Parkway Health Center	55 South Professional Way Payson, UT 84651

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 9/27/22 at 1:35 PM, an interview was conducted with Certified Nursing Assistant (CNA) 5. CNA 5 stated that resident showers were documented in the resident medical record and a shower sheet would be completed for each shower. CNA 5 stated that the shower sheets were signed off by the nursing staff. CNA 5 stated after the nursing staff signed the shower sheets they were uploaded into the resident's medical record by the Medical Record staff member. CNA 5 stated that a shower sheet would be completed after every shower and refusal. On 9/27/22 at 2:26 PM, an interview was conducted with CNA 6. CNA 6 stated that resident 22 had never refused a shower for her. CNA 6 stated that resident 22 was showered three times a week on Tuesday, Thursday, and Saturday. CNA 6 stated that resident 22 was able to complete approximately 75% of the shower on her own. CNA 6 stated that most days there was enough staff to complete showers. CNA 6 stated if the hallway was short staffed she would find someone to help with call lights so she could make sure that the residents were taken care of. On 9/29/22 at 12:34 PM, an interview was conducted with CNA 7. CNA 7 stated that the facility was short on staff. CNA 7 stated that she had seven showers to complete today with two CNAs staffed on the 100 and 200 hallway. CNA 7 stated that five of the seven residents were a two person extensive assistance. CNA 7 stated that the 100 and 200 hallway did not have a shower CNA and sometimes the showers got missed. CNA 7 stated that two showers had been completed today and one resident refused. CNA 7 stated that her goal was to get three showers completed each day. CNA 7 stated if a shower was missed she would pass it on in report and see if the next shift could complete the showers. CNA 7 stated if the next shift could not complete the showers she would try and complete the showers the next day. CNA 7 stated that resident 22 was a set up for showers. CNA 7 stated that after she set resident 22 up for a shower she would leave and give resident 22 privacy. CNA 7 stated that resident 22 needed assistance to wash her back and get dressed. CNA 7 stated that resident 22 was very involved in her care. CNA 7 stated that the shower sheets were getting missed because a lot of the staff did not know that they had to complete a shower sheet. CNA 7 further stated that the shower book did not have any shower sheets available and staff did not have a master copy to make copies. CNA 7 stated that she had a hard time answering resident call lights when there were only two CNAs staffed because most of the residents were a two person assistance. CNA 7 further stated the willingness of other staff to answer call lights was also a concern. 30563 2. Resident 25 was admitted to the facility on [DATE] with diagnoses which included hypothyroidism, hyperlipidemia, depression, hypertension, borderline personality disorder, pain, and edema. On 9/26/22 at 12:32 PM, an interview was conducted with resident 25. Resident 25 stated she should get a shower today, but did not get one because staff did not show up. Resident 25 stated she got a shower on 9/24/22, but did not have one for two weeks prior to that. Resident 25 stated she took showers by herself because she became very disgusted by herself. Resident 25's medical record was reviewed on 9/29/22. An admission MDS assessment dated [DATE], revealed resident 25 had a Brief Interview of Mental Status (BIMS) score of 11 which revealed mild cognitive impairment. The MDS further revealed resident 25 required one person limited assistance to transfer only and physical assistance with bathing. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465129	A. Building B. Wing	10/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A care plan with a problem start date of 7/29/22, and created on 7/31/22, revealed [Resident 25] is at risk for altered ADL [activities of daily living] function secondary to limited mobility. The goal was to not have any unaddressed complications secondary to decreased ADL self-performance, through next review. Approaches included assistance in completing ADL tasks each day, provide dignity and respect, and encourage independence; encourage us of call lights when ADL assistance was needed. There were shower sheets in resident 25's medical record dated 8/15/22 and 9/9/22. On 10/3/22 at 9:53 AM, an interview was conducted with CNA 2, CNA 9, and CNA 8. The CNA's stated there were shower schedules and a shower CNA that worked Tuesday through Saturday. CNA 2 stated there were shower sheets completed and charted in the computer after a shower was completed. CNA 8 stated they were out of shower sheets and the printer was not working to print out the shower sheets. CNA 2 stated there was a tab to document when ADLs were performed in the electronic medical record. On 10/3/22 at 12:08 PM, an interview was conducted with the Assistant Director of Nursing (ADON). The ADON stated resident 25 required two person supervision assistance with showers. The ADON stated there were enough staff to help resident 25 get a shower. The ADON stated for supervised residents, the staff provided the towels and if the resident wanted someone in the shower room the staff stayed in the shower room. 3. Resident 47 was admitted to the facility on [DATE] with diagnoses which included convulsions, severe intellectual disabilities, major depressive disorder, and dementia. On 9/26/22 at 10:41 AM, an observation was made of resident 47. Resident 47 was in the hallway with messy hair. Resident 47 stated she combed her hair on her own. At 12:05 PM, resident 47 was observed in the dining room with messy hair and with what appeared to be mucus on her chest. At 3:07 PM, resident 47 was observed with what appeared to be mucus on her shirt sitting in the television area. On 9/28/22 at 9:30 AM, an observation was made of resident 47. Resident 47 was observed in the salon getting her hair done. Resident 47's medical record was reviewed on 9/29/22. A quarterly MDS assessment dated [DATE], revealed resident 47 had a BIMS score of 4 which revealed severe cognitive impairment. The MDS further revealed resident 47 required one person physical assistance with physical help in part of bathing activity. A care plan with a problem start date of 1/31/22, revealed resident 47 was at risk for altered ADL function secondary to cognitive deficit and limited mobility. The goal was resident 47 would not have any unaddressed complications secondary to decreased ADL self-performance, through the next review. The approaches included to assist resident 47 to apply ankle foot orthosis to bilateral legs when out of bed; assist in completing ADL tasks each day; and encourage to use call lights when ADL assistance was needed. According to shower sheets in resident 47's medical record. Resident 47 was provided a shower on 7/5/22, 8/27/22, 9/10/22, 9/17/22, and 9/24/22. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465129	A. Building B. Wing	10/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Parkway Health Center	55 South Professional Way Payson, UT 84651

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/3/22 at 12:04 PM, an interview was conducted with the ADON. The ADON stated resident 47 did not usually refuse showers. The ADON stated resident 47 was good about getting into the shower. The ADON stated resident 47 required one person assistance with showers. 4. Resident 53 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included surgical aftercare following surgery, muscle weakness, lack of coordination, diabetes mellitus, sleep apnea, and generalized anxiety. On 9/26/22 at 2:41 PM, an interview was conducted with resident 53. Resident 53 stated he was scheduled for showers on Tuesday, Thursday, and Saturday but he did not always get his shower. Resident 53 stated he asked for a bed bath sometimes. Resident 53's medical record was reviewed on 9/29/22. A quarterly MDS assessment dated [DATE], revealed resident 53 required one person physical assistance in part of bathing. The MDS further revealed resident 53 had a BIMS score of 14 which revealed he was cognitively intact. A care plan dated problem onset of 8/1/22, and created on 9/19/22, revealed resident 53 was at risk for altered ADL function secondary to limited mobility and obesity. The goal was to not have any unaddressed complications secondary to decreased ADL self-performance, through the next review. Approaches included assistance bars to bed as least restrictive turning and repositioning device; assist in completing ADL tasks each day; encourage PT/OT [Physical Therapy/Occupational Therapy] services as prescribed. not applicable; encourage use of call lights when ADL assistance was needed. According to shower sheets in resident 53's medical record. Resident 53 was provided a shower on 1/26/22, 9/10/22, and 9/24/22. Resident 53's progress notes revealed the following entries: a. On 8/4/22, Pt [patient] complaining of not getting showered today and shower aide [CNA] has left for the day but will pass on report to be done tomorrow. b. On 8/26/22 at 2:00 PM, .got shower aide to help and give him a thorough shower. c. On 9/15/22 at 3:38 PM, the patient took a shower today. On 10/3/22 at 10:25 AM, an interview was conducted with the Director of Nursing (DON). The DON stated she knew staff had a shower schedule for residents and a shower CNA worked Tuesday through Saturday. The DON stated there were shower sheets that CNA's documented on after a shower was completed. (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/3/22 at 12:04 PM, an interview was conducted with the ADON. The ADON stated residents had scheduled shower days. The ADON stated the Restorative Nursing Assistant (RNA) provided showers to residents if she had RNA services to provide to the resident that day. The ADON stated there was also a shower CNA. The ADON stated there had been times the shower CNA had been pulled to the floor to help with call lights instead of showers. The ADON stated CNA's fill out a shower sheet and would check off if there were any skin problems. The ADON stated if a resident refused a shower, it was offered three times, different CNA's offered, the CNA would let the nurse know, and the CNA charted the resident refused. 38031 5. Resident 8 was admitted to the facility on [DATE] with diagnoses which included dementia without behavioral disturbance, hypokalemia, type 2 diabetes mellitus, chronic pain syndrome, hypertension, hypothyroidism, urinary tract infection, muscle weakness, abnormalities of gait and mobility, and hyperlipidemia. On 9/26/22 at 12:42 PM, an interview was conducted with resident 8. Resident 8 stated yah when asked if she received assistance with showers, but was not able to recall or state what days they were scheduled for. An observation was made of a black/brown substance packed under all of resident 8's fingernails on the left hand. On 9/26/22, resident 8's medical record was reviewed. On 6/16/22, resident 8's admission MDS assessment documented a BIMS of 8/15, which indicated moderately cognitively impaired. The assessment documented that the resident was a limited one person assistance for walking in room and in the corridor and was supervision with setup assist for locomotion on and off the unit. The resident was an extensive one person assistance for toileting, a one person limited assistance for personal hygiene, and required a one person assistance with physical help in bathing. The mobility devices used were documented as a walker and wheelchair. Review of resident 8's care plan revealed a care area for at risk for altered ADL function secondary to limited mobility and cognitive deficits and was initiated on 9/26/22. Interventions included assist in completing ADL tasks each day; provide dignity and respect and encourage independence; and encourage use of call lights when ADL assistance was needed. Review of resident 8's shower sheets revealed the following: a. On 7/4/22, resident 8 refused a shower. b. On 7/21/22, the shower sheet documented that oral care, nail care, shaving, lotion application, comb hair out, and a shower was provided. c. On 8/12/22, the shower sheet documented that oral care, nail care, shaving, lotion application, comb hair out, and a shower was provided. It should be noted that 22 days had lapsed since the last documented shower. d. On 8/15/22, the shower sheet documented that oral care, nail care, shaving and a shower were provided. (continued on next page)

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	465129	A. Building B. Wing	10/03/2022

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	e. On 9/7/22, the shower sheet was dated but did not document if any bathing or hygiene was provided. It should be noted that 22 days had lapsed since the last documented shower. f. On 9/15/22, the shower sheet documented that oral care, nail care, shaving, lotion application, comb hair out, and a shower was provided. It should be noted that 8 days lapsed since the last documented shower. g. On 9/26/22, resident 8 refused a shower. It should be noted that 11 days had lapsed since the last documented shower was offered. h. On 9/28/22, resident 8 refused a shower. On 9/28/22 at 8:28 AM, resident 8's fingernails on the left hand were observed dirty and packed with a black/brownish substance underneath. On 9/29/22 at 8:13 AM, an interview was conducted with Registered Nurse (RN) 5. RN 5 stated that the facility had a shower CNA Tuesday through Saturday. Resident 8 was observed talking to RN 5. Resident 8 was observed wearing the same shirt that was worn since 9/27/22. On 9/29/22 at 8:14 AM, an interview was conducted with CNA 4. CNA 4 stated that she was the shower CNA on Tuesdays through Saturday. CNA 4 stated that resident 8 was scheduled for showers on Monday, Wednesday, and Fridays. CNA 4 stated that resident 8 required limited assistance with showers, and she provided the resident with towels and supplies. CNA 4 stated that she assisted with washing resident 8's back, legs and hair, and then assisted the resident with dressing after the shower was completed. CNA 4 stated that sometimes if resident 8 refused a regular shower then a bed bath would be offered. CNA 4 stated that resident 8 usually refused showers but they would approach a few times a day. CNA 4 stated that documentation of showers that were provided and any refusals were completed on the shower sheet. CNA 4 stated that when she assisted with the showers she cleaned the resident's hands with a wash cloth and also cut the resident's fingernails. A shower sheet was observed taped to the nurse's station, and was dated 9/25/22 to 10/2/22. Resident 8's shower schedule was documented as a morning shower on Sunday, Monday, Wednesday, and Friday. The form documented that resident 8 refused on Monday (9/26/22) and Wednesday (9/28/22).

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	465129	A. Building B. Wing	10/03/2022

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30563 Based on interview and record review, it was determined, the facility did not ensure that residents received treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan and the residents' choice. Specifically, for 1 out of 34 sampled residents, a resident was admitted with two different admission orders, a chest x-ray revealed congestive heart failure with edema and no interventions were provided, a cardiologist had different medication orders, and laboratory services were not provided according to physician's orders. Resident identifier: 160. Findings included: Resident 160 was admitted to the facility on [DATE] and discharged on [DATE] with diagnoses which included hypertension, diabetes mellitus, and atrial fibrillation. On 9/27/22 at 9:21 AM, a phone interview was conducted with resident 160's family member. Resident 160's family member stated resident 160's medications were all messed up when she was admitted . Resident 160's family member stated resident 160 should have had Torsemide as needed when she was having edema in her lungs. Resident 160's family member stated resident 160 was provided oxygen and another medication for her heart rhythm instead of the Torsemide. Resident 160's family member stated she took resident 160 to the cardiologist and resident 160 was not receiving the same medications. Resident 160's family member stated she talked to the previous Director of Nursing (DON) about the medications. Resident 160's medical record was reviewed on 9/29/22. An admission Minimum Data Set (MDS) assessment dated [DATE], revealed resident 160 received an anticoagulant six days out of the previous seven days. A care plan dated 1/5/22, revealed [Resident 160] has atrial fibrillation and takes anticoagulant medications. The goal was The resident will be free from discomfort or adverse reactions related to anticoagulant use through the review date. The approaches were Administer ANTICOAGULANT medications as ordered by physician. Monitor for side effects and effectiveness Q [every]-SHIFT. and Resident/family/caregiver teaching to include the following: Take/give medication at the same time each day, Use soft toothbrush, Use electric razor, Avoid activities that could result in injury, Take precautions to avoid falls, Signs/symptoms of bleeding, Avoid foods high in Vitamin K. These include greens such as spinach and turnips, asparagus, broccoli, cabbage, Brussels sprouts, milk and cheese. and Review medication list for adverse interactions. Avoid use of aspirin or NSAIDS [Non-steroidal anti-inflammatory drug]. There were two Admission orders in resident 160's medical record. One was generated on 1/4/22, with an admitted to the hospital of 8/2/21. The other was dated 12/24/21. The medications that were printed on 1/4/22, revealed to have Torsemide 20 Milligrams (mg) orally daily, Ferrous Sulfate 325 mg every day, Vitamin B12 1000 mg/milliliter injection every 30 days, and Potassium Citrate 540 mg with an unknown dose. (continued on next page)

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	465129	A. Building B. Wing	10/03/2022

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident 160's January 2022 Medication Administration record (MAR) was reviewed. Resident 160 was not provided Torsemide, Ferrous Sulfate, Vitamin B12, and Potassium Citrate. There was no information that the physician was contacted regarding the double admission orders and which medications to administer. A chest x-ray obtained on 3/22/22, revealed resident 160 had Bilateral infiltrates. Left pleural effusion, Question congestive heart failure with edema. There were no nurses notes regarding why a chest x-ray was obtained or that the results were received. There was a scribble at the bottom of the form and no other information located in resident 160's medical record. A form titled Referral to Physicians and Clinics dated 3/23/22, revealed that resident 160 went to a cardiology appointment. The physician ordered to have a complete blood count, comprehensive metabolic panel, Lipids, B-type natriuretic peptide, and a thyroid stimulating hormone to be obtained. In addition, the cardiologist wrote Please give Furosemide and potassium in the AM [morning] so she isn't peeing all night. The cardiologist listed resident 160's current medications which included Vitamin D3 50 micrograms (mcg) daily and Metoprolol Tartrate 50 mg twice daily. A basic metabolic panel dated 3/23/22, was located in resident 160's medical record. There were no other laboratory results located. Resident 160's March 2022 MAR was reviewed and resident 160 was administered Vitamin D 1000 International Unit (IU) by mouth once daily since 1/6/22. Metoprolol Succinate capsule Extended release (ER) 24 hour sprinkle 50 mg was administered twice daily. The Furosemide Tablet 40 mg was not administered from 3/23/22, until resident 160 was discharged . It should be noted that Vitamin D3 50 mcg and Vitamin D 1000 IU were not the same dosage. The March 2022 MAR revealed that resident 160 was not administered Metoprolol Succinate Capsule ER 24 hour sprinkle 50 mg on the following dates: a. On 3/6/22, 7:00 PM dose. b. On 3/8/22, 7:00 AM and 7:00 PM doses. c. On 3/9/22, 7:00 AM and 7:00 PM dose. d. On 3/10/22, 7:00 PM dose. e. On 3/11/22, 7:00 AM dose. f. On 3/12/22, 7:00 PM dose. g. On 3/13/22 7:00 AM dose. (continued on next page)

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	465129	A. Building B. Wing	10/03/2022

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The progress notes revealed on 3/6/22, the drug was not on hand. On 3/8/22, the medication was pending delivery. On 3/9/22, Medication was not available. Notified pharmacy. Refill is too soon, notified DON and MD [Medical Doctor] and Pending Delivery. On 3/10/22, Unable to locate. Ordered more. On 3/11/22, Drug not available. On 3/12/22, medication not on hand pharm [pharmacy] notified. On 3/13/22, Medication cannot be filled until the 16th. Notified DON of issue. Notified MD. Progress notes revealed the following entries: a. On 4/6/22 at 1:14 PM, Social Services Note: Spoke with [resident 160's] daughter [name removed] She let me know her mom will be going to another facility for rehab [rehabilitation] and then hopefully to the asssited (sic) living. Her daughter was concerned over medications and if she maybe was not getting them. [Name removed] [NAME] was spoke to and looked into things her mom was getting meds [medications]. [Name removed] said she still feels better just starting somewhere fresh. Has been speaking with [physician's name removed] at the hospital who also is here and it has been good as he knows her mom. I told her to please let us know if she needs anything and we hope she gets better. b. On 4/6/22 at 1:48 PM, Social Services Note: Called and spoke to daughter with [name removed] [NAME] and [name removed] the nurse. Went over her meds and that concern. Letting her know she was getting them, addressed the concern with her low blood pressure, explaining that ambulance came and gave her ketsmine (sic) for pain and sedation which most likely caused blood pressure and heart rate to drop. Daughter was appreciative of our call. On 9/27/22 at 12:01 PM, an interview was conducted with Registered Nurse (RN) 5. RN 5 stated she had worked at the facility for two years and was currently an agency nurse. RN 5 stated that nurses had to track down admission paperwork. RN 5 stated admission orders were double checked with the admission staff member. RN 5 stated that outside appointments were made by Transportation. RN 5 stated that Transportation gave the orders to the nurse, and the nurse inputted the orders into the electronic medical record. RN 5 stated a lot of times the resident's returned with no new orders or information from the appointments. RN 5 stated the laboratory came Monday and Friday to get the samples. RN 5 stated if the sample was sent to hospital, then the nurse had to call the hospital to check because the hospital did not notify the facility staff of the results. RN 5 stated if a resident continued to complain of symptoms of a urinary tract infection, then nurses made sure a urinalysis was done and then called for results. RN 5 stated she believed there was a difference between Metoprolol Tartrate and Succinate but would have to verify which medication and ask the pharmacy which one should be used. RN 5 stated if medication was not available nurses would have to write it down on a sheet and then call into pharmacy. RN 5 stated the new system had a button to push to reorder the medications. RN 5 stated that the night shift nurse went through and re-ordered the medications before the medication ran out. RN 5 stated if a resident was not administered Metoprolol, then she would want to make sure their blood pressures were not high. RN 5 stated sometimes Metoprolol was not given because the blood pressure was too low. RN 5 stated sometimes the physician provided parameters to hold the medication depending on the resident's blood pressure. On 9/27/22 at approximately 1:00 PM, an interview was conducted with the Corporate MDS Coordinator (CMDSC). The CMDSC stated she was unable to locate laboratory results for resident 160. (continued on next page)

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	465129	A. Building B. Wing	10/03/2022

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/27/22 at 2:50 PM, an interview was conducted with the DON. The DON stated admission orders were faxed to the pharmacy from the hospital and the pharmacy filled medications based on the physician's orders. The DON stated there was a central intake team that entered in all of the admission physician's orders from the hospital referral. The DON stated the central intake team called to verify if there were conflicting orders. The DON stated a nurse and the DON then verified the orders. The DON stated there was a concern about not updating orders with what the physician wanted. The DON stated she would have to see if there was a difference between Metoprolol Succinate and Tartrate. The DON stated that families were not always notified of chest x-ray results. The DON stated she did not know resident 160 and would not know if the results should have been reported to the family. The DON stated she had to look into why the Metoprolol was not administered and why there was not clarification with the Cardiologist after the appointment. The DON stated she would need to look at the laboratory results to see if the labs were obtained. On 9/29/22 at 1:00 PM, a follow up interview was conducted with the DON. The DON stated that the two different admission medications, should have been clarified with the physician. The DON stated that she would have used the orders from 12/24/21. The DON stated that she would not expect her nurses to review the cardiologist medications when the resident returned from the appointment because staff should have sent a copy of their current medications to the appointment. At 2:11 PM, the DON stated with the continue current medications list from the Cardiologist, she would not expect the nurse to change the orders but to reach out and make sure the Cardiologist knew what medications the resident was receiving.

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	465129	A. Building B. Wing	10/03/2022

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45470 Based on observation, interview, and record review it was determined, for 5 out of 34 sampled residents, that the facility failed to ensure that the resident environment remained as free of accident hazards as was possible and each resident received adequate supervision and assistance devices to prevent accidents. Specifically, multiple residents did not receive preventative interventions and/or adequate supervision to prevent future falls. In addition, a resident with a history of wandering did not receive adequate supervision to prevent accidents and the resident did not receive adequate supervision due to being an unsafe smoker. Resident identifiers: 8, 43, 49, 53, and 155. Findings included: 1. Resident 155 was admitted to the facility on [DATE] with diagnoses which included unspecified fracture of left femur, hyperkalemia, nonrheumatic aortic stenosis, and acute on chronic combined systolic and diastolic heart failure. On 9/27/22, resident 155's medical record was reviewed. A progress note dated 9/11/22 at 3:33 PM, revealed that resident 155 was here with a L [Left] hip fx [fracture] after a fall. Resident 155's care plan was reviewed, and it revealed that there was no care plan related to falls. On 9/7/22 at 5:19 PM a Nursing Progress Note revealed, Res [resident] had fall, called to shower by CNA [Certified Nursing Assistant] res was lying on back. Res said he slipped. Fall was not witnessed. Res denied pain at this time. Assessed, no apparent injury at time. Neuro [neurological] checks started and were wnl [within normal limits] . [Note: A fall care plan was not developed.] On 9/27/22 at 3:18 PM, an interview with the Director of Nursing (DON) was conducted. The DON stated that if a resident came to the facility with recent falls, there should be a baseline care plan for falls. 2. Resident 43 was admitted to the facility on [DATE] with diagnoses which included dehydration, major depressive disorder, anxiety disorder, orthostatic hypotension, muscle weakness, and abnormalities of gait and mobility. On 9/27/22, resident 43's medical record was reviewed. A care plan dated 8/20/22, and revised 8/30/22, revealed that resident 43 was at risk for falls related to a history of falls, history of Parkinson's Disease, and hypertension. The goal was the resident would have no unaddressed falls through next review. Approaches included monitoring for orthostatic hypotension which was created on 8/20/22, encourage to use the call light and ask for assistance when transferring or ambulating which was created on 8/24/22, and to encourage resident to increase fluid intake which was created on 8/25/22. (continued on next page)

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	465129	A. Building B. Wing	10/03/2022

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A progress note dated 8/19/22 at 6:42 PM, revealed, Res is fall risk, uses walker, unsteady gait. Resident has confusion and is scared and afraid to be here without family . A progress note dated 8/20/22 at 10:46 AM, revealed, Pt [patient] was in room this morning on own, staff was doing regular duties when housekeeping told CNA that pt had fallen in room and was bleeding. Upon staff entering room pt was back in bed. With further inspection a pool of blood was noted on bathroom floor but pt was able to get self into bed. Upon initial assessment pt was confused on where he was or why he was here but knew who he was. Wound on right back of head was bleeding - nurse cleaned up and notified DON [Director of Nursing] . Neuro checks are in place and pt is in front sitting room in view of nursing station to be watched until further information is gained. A progress note dated 8/24/22 at 11:12 AM, revealed, Aid [CNA] went into residents room to check on him, resident was found in bed, resident was on the phone with his wife who told aid that he had fallen. Neuros started. A progress note dated 8/25/22 at 11:59 PM, revealed, Patient was found on the floor. He stated that he did not hit his head. He has an abrasion on lower back. Nurse did an assessment before he was transferred to his bed. Patient is alter and oriented. Resident 43's face sheet revealed that resident 43 was discharged to home on 9/10/22. On 9/28/22 at 9:45 AM, an interview with CNA 2 was conducted. CNA 2 stated that there was not enough staff at the facility to prevent residents from falling. CNA 2 stated that the facility often staffed two or three CNAs for the entire building, which was not enough to adequately supervise residents who were a fall risk. CNA 2 stated that in addition to not having enough staff, communication between nurses and CNAs was lacking, and CNA's were often not aware if resident were a fall risk. On 9/28/22 at 10:00 AM, an interview with CNA 8 was conducted. CNA 8 stated that on some shifts there were only two CNAs in the facility. CNA 8 stated that the facility needed more CNAs to supervise residents who were a fall risk because there was not enough staff to prevent residents from falling. 30563 3. Resident 53 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included surgical aftercare following surgery, muscle weakness, lack of coordination, diabetes mellitus, sleep apnea, and generalized anxiety. On 9/26/22 at 2:33 PM, an interview was conducted with resident 53. Resident 53 stated he was transferring from the wheelchair to bed and his ankle gave out and he fell to the ground. Resident 53 stated his left shoulder always hurts but it hurt more since the fall. Resident 53 stated he was waiting for staff but staff did not come. Resident 53 stated he waited for 15 to 20 minutes and was tired from returning from a doctors appointment so he transferred himself. Resident 53 stated it took 20 to 30 minutes for someone to come and he did not want to wait. Resident 53's medical record was reviewed on 9/29/22. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465129	A. Building B. Wing	10/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Parkway Health Center	55 South Professional Way Payson, UT 84651

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A quarterly Minimum Data Set (MDS) dated [DATE], revealed resident 53 had a Brief Interview of Mental Status (BIMS) score of 14 which indicated he was cognitively intact. The MDS revealed that resident 53 required extensive assistance with two plus person physical assistance. The MDS revealed resident 53 had not had a fall in the last month, the last two to six months, or since admission. A care plan dated 5/10/19, and revised on 10/5/21, revealed resident 53 was at risk for falls related to impaired mobility, morbid obesity, and weakness. The goal was the resident would be free of falls through the review date. Approaches included anticipate and meet the resident's needs; call light within reach; resident needs prompt response to all requests for assistance; educate what to do if a fall occurs; and review information on past falls and attempt to determine cause of fall. An approach dated 9/22/20, revealed change position slowly to reduce change of hypotensive episodes. An updated fall care plan with a problem start date of 8/1/22, and created on 9/19/22, revealed that resident 53 was at risk for falls secondary to limited mobility and weakness. The goal was resident 53 would have no untreated injuries related to falls through next review. The approaches included encourage the use of call light and keep room free of clutter and tripping hazards. Progress notes revealed the following entries: a. On 6/3/22 at 12:20 PM, [Incident Report] Three CNA's were trying to reposition the patient in bed around 11am. [CNA name] and [CNA name] where pulling the patient in one direction and the agency CNA was pulling the patient in another. During the transition, I was told by [CNA name] that he fell off of the bed. I went in and assessed him. He didn't have any skin tares (sic) or abnormalities. He was oriented times four. He said his left hip hurts when he moves. He said it was an achy muscle pain. I checked it out and there was no bruise present at the time. I informed the other agency nurse working on his hall to continue to check on him by the hour even though I was told that he didn't hit his head. I notified [Nurse Practitioner's name] via tiger text and havent heard a response back as of yet. b. On 6/3/22 at 12:24 PM, CNA and 300 hall nurse reported that patient fell while transferring from his w/c [wheelchair] to his bed. Pt returned back from the appointment and got helped by CNA to his bed and slid down on his buttocks to the ground. physical assessment completed that no changes of cognitively, no skin issues noted without redness or bruise, no changes ROM [range of motion], but pt c/o [complains of] pain 6 out of 10 to left hip, scheduled norco 2 tablets given. notified 300 hall nurse about the assessment including pain and she will notify to NP [Nurse Practitioner]today, will continue to monitor any changes. [Note: An incident report was not completed.] c. On 7/29/22 at 6:57 PM, Pt had Dr [doctor] appt [appointment] today., after returning CNA was getting him into bed via hoyer and pt slipped out of chair. Pt did not report any pain from the fall and did not hit head. Has no new pain from the witness fall and bs [blood sugar] & vitals are normal for pt post fall. Event report was made and signed. There was a incident report completed for the fall on 7/29/22 at 5:53 PM. The report revealed resident 53 had a witnessed fall. Resident 53 slipped out of the chair onto the floor onto his buttocks. The immediate action taken was nurse and additional two CNA's assisted patient back into bed with a hoyer lift. No issues and patient reported to be fine. Vital signs were obtained and all were normal. The incident report revealed that there were no interventions developed after the fall. (continued on next page)

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	465129	A. Building B. Wing	10/03/2022

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/3/22 at 11:37 AM, an interview was conducted with the Assistant Director of Nursing (ADON). The ADON stated if a resident fell , the nurses completed a risk management report, assessed the resident, obtained vital signs, assessed for injuries, then started a neurological check sheet. The ADON stated the nurses should contact the DON, physician, and family. The ADON stated once the fall was reported to the physician, the staff would send the resident to the hospital if there was a major injury. The ADON stated if there was a minor fall then neurological checks were completed, a change of condition, a progress note, and the risk management report were completed. The ADON stated that agency staff were made aware at shift changes about resident falls. The ADON stated there was also a binder at the nurses station for agency staff members but mostly information was provided from the nurse to nurse report. The ADON stated the management team completed an Interdisciplinary Team (IDT) meeting with the family, nursing team, social services, and therapy. The ADON stated the IDT team looked for fall trends and then referred to the Restorative Nursing Assistant (RNA) program or therapy. The ADON stated new interventions were care planned. The ADON stated that resident 53 had a new care plan dated 8/1/22, in the new electronic medical record. The ADON observed the previous care plans and stated there were no interventions after the the two falls on 6/3/22. The ADON stated for the fall on 7/29/22, the CNA was transferring resident 53 to his wheelchair when resident 53's legs gave out. The ADON stated resident 53 usually used the sit to stand lift and not a hoyer lift for transfers. The ADON stated the CNA could have used the hoyer lift if resident 53 was to weak to stand up on his own. The ADON stated according to the incident report resident 53 slid out of his chair and onto the floor. The ADON stated that the staff used a hoyer lift to get resident 53 off the floor and into bed. [Note: The nursing progress note on 7/29/22, revealed .after returning CNA was getting him into bed via hoyer and pt slipped out of chair.] On 10/3/22 at 11:26 AM, an interview was conducted with CNA 9. CNA 9 stated there was a CNA chart that had which residents fell and which residents were a high fall risk. CNA 9 stated the residents had signs inside their rooms and it was in the electronic charting system. CNA 9 stated she had no idea how Agency staff knew a residents transfer status or if the resident was a fall risk. CNA 9 stated Agency had a binder but she did not know what was in the binder. CNA 9 stated resident 53 required one person assistance with transfers, bed mobility, and showering. CNA 9 stated there was no reason that three people would be providing bed mobility. On 10/3/22 at 3:41 PM, an interview was conducted with the DON. The DON stated there were no incident reports after the falls on 6/3/22. 33215 4. Resident 49 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included, but not limited to, hemorrhage of anus and rectum, dementia, history of falling, type 2 diabetes mellitus with hyperglycemia, displaced fracture of second cervical vertebra, major depressive disorder, systolic congestive heart failure, secondary hypertension, and edema. On 9/26/22 at 12:04 PM, an interview was conducted with resident 49. Resident 49 stated that he had fallen three times since he was admitted to the facility. Resident 49 was unable to give any details regarding the three falls and resident 49 could not remember if he had any injuries with the three falls. Resident 49 stated that he had fallen at home and was in a back brace when he admitted to the facility. Resident 49 stated that recently he was taken out of the back brace and given a neck brace. Resident 49 was observed to have a neck brace on. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465129	A. Building B. Wing	10/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Parkway Health Center	55 South Professional Way Payson, UT 84651

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident 49's medical record was reviewed on 9/27/22. An admission MDS assessment dated [DATE], documented that resident 49 had a BIMS score of 3. A BIMS score of 0 to 7 indicates severely impaired cognition. In addition, resident 49 was documented as requiring extensive assistance of two persons for bed mobility. Resident 49 required extensive assistance of one person for transfers, locomotion on and off the unit, dressing, toilet use, and personal hygiene. Resident 49 required limited assistance of one person for walk in room and walk in corridor. Resident 49 was not steady moving from a seated to standing position, walking, turning around and facing the other direction while walking, moving on and off the toilet, and surface to surface transfers between bed and chair or wheelchair. Resident 49 was only able to stabilize with human assistance. The MDS Care Area Assessment (CAA) Summary dated 7/13/22, documented a Care Area Triggered for falls. In addition, the CAA Summary documented that falls were addressed in the care plan. [Note: A fall care plan was not created until 9/22/22.] On 7/6/22 at 12:59 PM, a Social Services Note documented Admit [Admission] Note: [Name of resident 49 removed] is an 80 YO [year old] widower who admitted from [name of hospital removed] on 6/30 [22] after sustaining an unwitnessed fall resulting in a C1-2 [cervical vertebrae] fx. On 7/29/22 at 1:30 AM, a Morse Fall Scale was completed and resident 49 was assessed as High Risk for falling with a score of 65. A Morse Fall score 45 or higher indicates a high risk for falls. [Note: Additional fall risk assessments were unable to be located for resident 49.] On 7/29/22 at 2:21 AM, a Nurses Note documented Patient had an injury fall this shift at 0130 [1:30 AM], assisted to the fall by CNA. CNA notified this Nurse. Pt states he lost his balance. Denies pain at this time. Offered medication. Skin tear on right elbow (1cm [centimeter] X [by] 1xcm) and abrasion on right knee (3. 5cm X 2cm). New injuries cleansed with wound cleanser, pat dry, and bacitracin applied. MD [Medical Director] Notified. [Note: A care plan was not created addressing falls after resident 49 had a fall on 7/29/22.] On 9/1/22 at 8:45 PM, a Nursing progress note documented Patient fell on his back while attempting to get off the toilet. The fall was unwitnessed. Patient has a skin tear R [right] wrist. His neuro check are normal and vitals [vital signs] are at baseline. Physician and family has been contacted. Patient is complaining of back pain but is refusing to get checked at the hospital. [Note: A care plan was not created addressing falls after resident 49 had a fall on 9/1/22.] On 9/5/22 at 10:26 PM, a Nursing note documented Resident had an assisted fall at 2200 [10:00 PM]. CNA was with resident in the bathroom. Resident was transferring to the toilet. CNA had already pulled wheelchair away. Resident had decided to sit down, not on the toilet. CNA caught resident and helped resident to the floor. 2 cnas and nurse helped resident get back into bed using hoyer lift. Resident did not hit head nor any other parts of his body. Resident is resting in bed. Vitals wnl. [Note: A care plan was not created addressing falls after resident 49 had a fall on 9/5/22.] (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465129	A. Building B. Wing	10/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A care plan Problem created on 9/22/22, documented Category: Falls [name of resident 49 removed is at risk for falls secondary to Weakness. A care plan Goal created on 9/22/22, documented Long Term Goal Target Date: 12/22/2022 [Name of resident 49 removed] will have no untreated injuries r/t [related to] falls, through next review. The care plan interventions created on 9/22/22, included: a. One on one activities evaluation and treatments if appropriate. b. Assist resident 49 with visual needs and visual appliance application and removal, as needed. c. Encourage the use of the call light. d. Evaluate the need to pace activities and plan rest periods, as tolerated. e. Keep room free of clutter and tripping hazards. f. Low bed without mat. g. Non-skid socks on at all times, as tolerated. h. Resident 49 had been educated on the call light function and use. A care plan Problem edited on 9/26/22, documented a Problem start date of 9/5/22. Category: Falls [Name of resident 49 removed] had an actual fall 9/1/22 and 9/5/22. A care plan Goal created on 9/26/22, documented Long Term Goal Target Date: 12/05/2022 [Name of resident 49 removed] will have no unaddressed complication or injury r/t fall through next review. The care plan interventions created on 9/26/22, documented an Approach start date of 9/5/22. The interventions included: a. Encourage resident 49 to use call light for assistance. b. Lowered to floor: continue plan of care with staff assistance with cares and toileting. On 9/27/22 at 1:35 PM, an interview was conducted with CNA 5. CNA 5 stated that he had only worked at the facility for four days but CNA 5 was familiar with resident 49's cares. CNA 5 stated that resident 49 would use the call light if he needed to use the bathroom. CNA 5 stated that resident 49 was a one person assistance with toileting. CNA 5 stated that resident 49 required a boost to get off the toilet but resident 49 would use the safety bar for stability. CNA 5 stated that resident 49 thought that he was continent and more often then not resident 49 was soaked. CNA 5 stated that staff check on resident 49 every two hours so that resident 49 was not soaked through his clothes but resident 49 usually was. CNA 5 stated that resident 49 required meal set up and finding where everything was on the tray. CNA 5 stated that he would assist resident 49 with opening small items. CNA 5 stated that resident 49 would ask the same question over and over. CNA 5 stated that resident 49 was a fall risk but resident 49 wound not try to get up on his own. CNA 5 stated that if resident 49 did get up on his own resident 49 would fall. CNA 5 stated there was nothing posted in resident 49's room regarding fall interventions. CNA 5 stated that resident 49 would always ask for help and was previously a fall risk. (continued on next page)

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	465129	A. Building B. Wing	10/03/2022

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 9/27/22 at 3:12 PM, an interview was conducted with the DON. The DON stated that the MDS coordinator would help get baseline care plans started. The DON stated that baseline care plans were basic care plans. The DON stated the comprehensive assessment CAA Summary areas should be care planned by the MDS coordinator. The DON stated the nursing team should be looking at resident change of condition or something specific to the resident that needed to be care planned. The DON stated that the administrative nursing team would complete the care plan updates. The DON stated if a resident came from the hospital with a fall she would expect the fall to be care planned. The DON stated if a resident had a fall or change in elevation, the staff were to assess the resident prior to moving the resident off what ever surface they were on. The DON stated staff were to look for obvious injuries, conduct range of motion prior to moving the resident, and complete a pain assessment. The DON stated that staff were to notify the practitioner if the resident had complaints of pain to see if anything additional should be implemented for the resident. The DON stated that staff were to notify the responsible party. The DON stated that the responsible party could be the resident or a family member. The DON stated that staff were to notify the practitioner, and an Event or incident report should be documented, and any new orders should be implemented. The DON stated the Event or incident report should have documentation of notification. The DON stated if the resident had an unwitnessed fall the staff should be doing neuro checks on the resident. The DON further stated if a resident needed to be transferred out of the facility staff should complete a change of condition transfer form. 38031 5. Resident 8 was admitted to the facility on [DATE] with diagnoses which included dementia without behavioral disturbance, hypokalemia, type 2 diabetes mellitus, chronic pain syndrome, hypertension, hypothyroidism, urinary tract infection, muscle weakness, abnormalities of gait and mobility, and hyperlipidemia. On 9/26/22 at 10:21 AM, an interview was conducted with CNA 1. CNA 1 stated that resident 8 was confused and had some short-term memory deficits. CNA 1 stated that resident 8 knew where she was and understood what was going on. CNA 1 stated that resident 8 wandered and went for walks around the building. CNA 1 stated that resident 8 used a cane for a mobility device. CNA 1 stated that resident 8 was frequently outside smoking and would wander to the other side of the building to look at the baby horse. On 9/26/22, resident 8's medical record was reviewed. On 8/15/22, a Smoking Risk assessment was completed for resident 8. Resident 8's assessment documented that the resident borrowed cigarettes and a lighter from others and smoked every few hours. The assessment documented that resident 8 scored a 1, which indicated a minimal problem for the following areas: smoking in unauthorized areas; was careless with smoking materials - drops cigarette butts or matches on floor, furniture, self or others; burns finger tips; burns clothes; smokes near oxygen; smokes in the facility; inappropriately provided smoking materials to others; general awareness and ability to understand the facility safe smoking policy; and capability to follow the safe smoking policy. The assessment documented that resident 8 scored a 3 or severe problem with begging or stealing smoking materials from others. The assessment documented a total score of 10 which indicated a potentially unsafe smoker. (continued on next page)

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	465129	A. Building B. Wing	10/03/2022

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A second undated smoking assessment documented that resident 8's total score of 6, which would indicate safe to smoke. The assessment documented that resident 8 scored a 3 or moderate problem for smokes cigarettes/butts from the ash tray and begs or steals smoking materials from others. The assessment documented a score of 1 which indicated a minimal problem for general behavior and interpersonal interaction, and mobility. The assessment documented that resident 8 was not ready to accept smoking cessation materials. On 6/16/22, resident 8's admission MDS assessment documented a BIMS of 8/15, which indicated moderately cognitively impaired. The assessment did not address the short term and long-term memory. The assessment documented that resident 8 was a limited one person assistance for walking in room and in the corridor and was supervision with setup assistance for locomotion on and off the unit. The mobility devices used were documented as a walker and wheelchair. Review of resident 8's progress notes revealed the following: a. On 7/9/22 at 5:56 PM, the nurse's note documented, Resident noted with bright red sunburn and purple areas to both arms. Resident enjoys spending a lot of time outside and was asked if she would like to come in and give her skin a rest for a little while. She refused. Nurse offered to bring her a long sleeve shirt to protect her arms which she also refused. Ointment applied to both arms. Resident denies pain. Nurse requested Sunscreen for resident. b. On 8/10/22 at 3:34 PM, the nurse's note documented, Patient doing well after her fall on 8/9/22. She has not had any signs of neurological issues and all her vitals have been normal. c. On 8/13/22 at 10:31 AM, the nurse's note documented, No change since pt. had fall on 8/9/22. Pt. asking staff for help when needed and using cane for mobility when walking. Will continue to monitor. d. On 8/20/22 at 10:15 AM, the nurse's note documented, Pt's family member pointed out a bruise on the pt's right shoulder, assuming it's from the fall. it's a god (sic) size bruise. e. On 8/25/22 at 1:25 PM, the NP note documented that resident 8 was pleasantly confused. will often forget where she's going or where she is at. f. On 8/25/22 at 5:21 PM, the nurse's note documented, pt given baggie of 7 cigarettes this morning at 0700 [7:00 AM] and within two hours had smoked all 7 and trying to borrow cigarettes' from other patients and redirected multiple times, other patients stating she only gets two cigarettes a day and pt educated again on how many she gets and counted baggies in med cart with her with 7 in each bag for the week days g. On 9/4/22 at 10:31 AM, the nurse's note documented, pt is out of cigarettes since Friday and [family member] will not bring her cigarettes or money for cigarettes, patient notified and appears not happy. circling the outside building and outside trash cans looking for cigarette butts and unable to re-direct, tiger test sent to all staff r/t the above h. On 9/15/22 at 5:35 AM, the NP note documented, . remains confused. she continues to lack her own safety awareness. No new falls or other events. (continued on next page)

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	465129	A. Building B. Wing	10/03/2022

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 7/11/22, the Physical Therapy discharge summary documented that resident 8 had met the goal of decreased risk for falls as evidenced by (AEB) decreased score on the Timed Up and Go test to 18 seconds. The resident was safely able to ambulate 300 feet with supervision and occasional verbal and tactile cues. The patient was independent with supervision times one for walking after donning shoes, able to ambulate inside and outside of facility and navigate around obstacles with supervision. Discharge recommendations were to continue to walk with supervision and use of quad cane. On 8/9/22 at 1:43 PM, an incident report documented that resident 8 had an unwitnessed fall. The form documented that the patient was out in the courtyard alone. A resident noticed resident 8 and notified staff that she had fallen. Resident 8 stated that she did not hit her head nor have any wounds. Factors identified at the time of the fall were that resident 8 had lost balance, and was attempting to self-transfer. The report documented that resident 8 did not complain of pain and no injuries were noted. No documentation was found of an elopement or wander risk assessment for resident 8. Review of resident 8's care plans revealed the following: a. On 9/27/22, a care area of cognitive loss/dementia was initiated. The care plan documented that resident 8 had memory/recall problems related to dementia AEB a poor BIMS score. Interventions identified were engage resident in conversations or activity of choice; and reorient as tolerated and do not criticize. b. On 9/27/22, a care area of exhibits alteration in thought process manifested by cognitive impairment r/t dementia; needs reminders/prompts/cues to choose activities was initiated. Interventions identified were to invite, encourage and involve resident 8 in activities of importance; post calendar in room; provide with opportunities to recall long/short term memories during activities; and provide adaptations to activities as needed. c. On 9/27/22, a care area for tobacco use initiated. Interventions identified were to distract with an activity or conversation of choice when it was not smoking time; offer cessation information as desired; involve support person or Ombudsman as needed; praise resident 8 for being safe and responsible; resident will be able to follow the smoking policy with staff assist; and resident will not share or borrow tobacco products or paraphernalia from others. d. On 9/26/22, a care area for at risk for falls secondary to limited mobility, poor balance and poor safety awareness was initiated. Interventions identified were encourage to utilize cane when ambulating, encourage to use the call light, keep room free of clutter and tripping hazards. It should be noted that no care plan or interventions were developed for resident 8's wandering. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 9/27/22 at 1:32 PM, an interview was conducted with Registered Nurse (RN) 4. RN 4 stated that resident 8 asked for a cigarette and was told that she had to wait until 4:00 PM because she had one at 1:00 PM already. RN 4 stated that she told resident 8 that she had nine cigarettes remaining. RN 4 stated that resident 8's cigarettes were kept inside the medication cart, but not the lighter. RN 4 stated that resident 8 went through packs of cigarettes fast so they were trying to limit the amount she smoked. RN 4 stated that resident 8 had a cigarette at 1:00 PM and then returned immediately to ask for a second one. RN 4 stated that she reminded resident 8 that she had just smoked a cigarette and that she needed to wait until 4:00 PM for the next one. RN 4 stated that resident 8 smoked independently and that she was alert and oriented to person and place. RN 4 stated she was not sure if resident 8 was able to make her own decisions, or if she had that capacity. RN 4 stated that resident 8 did not have all of her faculties. RN 4 stated that resident 8 wandered and went outside to smoke. On 9/28/22 at 8:41 AM, an interview was conducted with RN 5. RN 5 stated that resident 8 could only have one cigarette every two hours. RN 5 stated that resident 8 would forget that she had smoked. 09/29/22 at 8:13 AM, a follow-up interview was conducted with RN 5. Resident 8 was observed to ask RN 5 for a cigarette. RN 5 stated that she did not have any cigarettes left in the medication cart and told resident 8 that she would go look for more. On 9/29/22 at 8:27 AM, an interview was conducted with CNA 2, RNA 1, and RN 5. CNA 2 stated that resident 8 had a fall outside the facility three or four months ago. CNA 2 stated they made sure to keep an eye on where resident 8 was going and made sure she did not go into the construction site that was nearby. CNA 2 stated that they would keep track of resident 8 by looking out the windows to locate her. CNA 2 stated that resident 8 had wandered into the construction area before to ask for cigarettes. CNA 2 stated that this had happened multiple times within a two-week period. CNA 2 stated that this occurred before resident 8 had her own cigarettes. CNA 2 stated that since resident 8 had access to her own cigarettes she had not wandered back over to the construction site. CNA 2 stated that resident 8 was an independent smoker and had her lighter in her possession. RNA 1 stated that resident 8's routine was to walk around the parameter of the building. RNA 1 stated that resident 8 would smoke the whole pack because she forgets. RN 5 stated that she had called resident 8's family member to inform them that resident 8 did not have anymore cigarettes at the facility. RN 5 stated that the family member was not going to bring anymore to resident 8 because she would be discharging home on Saturday. On 9/29/22 at 10:16 AM, an interview was conducted with RN 5. RN 5 stated that resident 8 had not h [TRUNCATED]

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465129	A. Building B. Wing	10/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Parkway Health Center	55 South Professional Way Payson, UT 84651

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0690 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30563 Based on interview and record review it was determined, for 2 out of 34 sampled residents, the facility did not ensure residents who were incontinent of bladder received appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. Specifically, a resident had a urinalysis (UA) test completed with no follow up and the resident went to hospital for treatment. In addition, a resident with signs and symptoms of a urinary tract infection (UTI) went to the hospital for treatment. Resident identifiers: 29 and 44. Findings included: 1. Resident 29 was admitted to the facility on [DATE] with diagnoses which included low back pain, injury to left lower leg, hypothyroidism, edema, chronic pain, and nausea. Resident 29's medical record was on 9/28/22. An admission Minimum Data Set assessment dated [DATE], revealed that resident 29 was occasionally incontinent of bowel and bladder and was not on a toileting program. The MDS further revealed resident 29 required two plus person extensive assistance with toileting. A care plan dated 8/1/22, revealed Infection. [Resident 29] is at risk for infection secondary to presence in a skilled nursing facility. The goal was [Resident 29] will have no untreated s/s [signs and symptoms] of infection through next review. The approaches included Monitor labs as prescribed, Notify MD [Medical Director] of s/s of infection, Universal precautions. A physician's order dated 8/19/22, written by Registered Nurse (RN) 3 revealed resident 29 was to have a UA, urine culture, and urine culture and sensitivity. The Laboratory Analysis results collected on 8/19/22, were received on 8/21/22. The laboratory (lab)results revealed resident 29 had Escherichia Coli, Peptostreptococcus prevotti, and Staphylococcus aureus. The form revealed that Macrobid 100 milligrams (mg) twice daily for 5 to 7 days was the appropriate treatment. Resident 29's August 2022 Medical Administration Record (MAR) revealed there were no antibiotics administered. There were no progress notes from 8/16/22 until 8/21/22. The progress notes revealed the following entries: (continued on next page)

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	465129	A. Building B. Wing	10/03/2022

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F 0690 Level of Harm - Actual harm Residents Affected - Few	a. On 8/21/22 at 3:25 AM, PT (patient) kept complaining about pain, and requested to talk to the doctor's about her medication regimen, she feels her current regimen isn't working. Pt was extremely upset. Pt did state she was at a 9 out of 10 and was still able to sleep. On the 1800 [6:00 PM] - 0600 [6:00 AM] shift, the CNA's [Certified Nursing Assistant] went to do their rounds and the pt was wearing the same brief from the previous night, stamped 0425 [4:25 AM] and when the CNA changed her, there was evidence of a BM [bowel movement], but not actual BM present, the pt wasn't cleaned well, and she was upset about it. b. On 8/21/22 at 10:28 AM, Resident 29 complained of pain and was requesting to go to the hospital emergency room . Resident 19 was angry narcotics had been spaced further out and Tramadol had been discontinued. Resident 19's vital signs were taken and as needed pain medication had been administered. The Assistant Director of Nursing (ADON) was notified and resident 19 was transferred to the hospital. c. On 8/21/22 at 11:55 AM, Resident 29 was taken by ambulance to the hospital emergency room . d. On 8/21/22 at 4:16 PM, Resident 29 returned to the facility with new orders for Tramadol 100 mg every 6 hours. e. On 8/24/22 at 12:35 PM, Resident 29 informed the nurse of the hospital situation. Resident 29 was happy to have her pain medication back. Resident 29 was frustrated that she had not gotten any results back from the hospital. An Emergency provider report dated 8/21/22 at 11:48 AM, revealed Resident 29 was in increased pain over the last day or so and she coordinates this with increasing urination and dysuria. The patient apparently had a catheter urine specimen obtained a day or 2 ago and they do not have the results as of yet. She is worried she has a kidney infection. According to the lab results interpretation section resident 29 had trace of leukocyte esterase, 1-3 bacteria per high-power field (hpf), [NAME] Blood Cells, and a few bacteria. The Discussion/Course section revealed complaints of a possible UTI and pain radiating into the right hip and knee. The lab tests were fairly unremarkable. The section revealed that she did not have evidence of a UTI today. Medications administered included Ceftriaxone Sodium 1 gram on 8/21/11 at 11:51 AM, through Intravenous route. [Note: There was no culture and sensitivity completed according to the lab results from the emergency department.] A Nurse Practitioner (NP) note dated 8/26/22, revealed that resident 29 was in pain over the weekend and she went to the hospital to have her Tramadol increased to every 6 hours. [Note: There was no information regarding resident 29's UA that was collected on 8/19/22.] On 9/29/22 at 10:44 AM, an interview was conducted with the Director of Nursing (DON). The DON stated symptoms of a UTI were increased urination, frequent urination, change in vital signs, fever, and a lot more. The DON stated if a resident had symptoms the a UA would be obtained. The DON stated there should be documentation in the progress notes as to why a UA was obtained. The DON stated physician's were notified through the UA results being placed in the box for the physician when they came to the facility. The DON stated nurses also sent a tiger text to the physician with the results. The DON stated the NP was at the facility on Mondays and Thursdays and the physician on Wednesdays. The DON stated she was unable to obtain the tiger texts unless she was in on the text, so she would not be able to provide information that the physician was notified. The DON stated when the physician was notified the nurse should write a progress note. (continued on next page)

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	465129	A. Building B. Wing	10/03/2022

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F 0690 Level of Harm - Actual harm Residents Affected - Few	On 9/29/22 at 11:00 AM, an interview was conducted with RN 3. RN 3 stated when a lab value or UA was ordered, she would contact the NP, an order was placed in the residents electronic medical record, and the lab company was contacted. RN 3 stated that the results of the laboratory were faxed to the facility or the lab contacted the NP. RN 3 stated that sometimes the lab did not send results so the nurse had to follow up with the lab. RN 3 stated if the nurse who ordered the labs was gone for a week the nurse on shift may not be aware of what labs had been ordered and which results had been sent to the facility. RN 3 stated the lab process had resulted in missed lab results. RN 3 stated that she tried to document in the progress notes when a lab was obtained. RN 3 stated on 8/19/22, she obtained a UA for resident 29 because she was probably acting confused or had a symptom like pain or burning when urinating. RN 3 stated she did not know if the physician was notified of the UA results. RN 3 stated she did not know if there was follow up because if it was not written in the medical record it was not done. RN 3 observed the UA results from 8/19/22, and stated it was a 6 on a scale of 1 to 7 which indicated resident 29 had an infection. RN 3 stated the results revealed resident 29 had a UTI that needed to be treated with Macrobid. RN 3 stated that things get very busy and I forget to get everything done. RN 3 stated there were not enough staff in the building. RN 3 stated there needed to be a nurse for each hallway because it's just crazy. RN 3 stated It's so stressful for me, because at the end of the day I sent the order and did not follow up on it and did not get treatment. RN 3 stated there were so many things to do and follow up on and with almost 40 residents it was impossible to get everything done. RN 3 stated that charting did not get done. On 9/29/22 at 12:38 PM, a follow up interview was conducted with the DON. The DON stated she did not have any notes about the UA. The DON stated according to the UA in the medical record, Macrobid was the antibiotic that should have been used to treat resident 29's UTI. On 9/29/22 at 1:00 PM, an interview was conducted with resident 29. Resident 29 stated that the facility obtained a UA on 8/19/22, but she did not know the results. Resident 29 stated she got a shot at the hospital because of her UTI on 8/21/22. Resident 29 stated she was in a lot of pain at the facility, so she had to go to the hospital to get treatment. Resident 29 stated she wonders if the facility ever received the results because she had asked a bunch of times and no staff knew about the results. On 10/3/22 at 12:01 PM, an interview was conducted with the ADON. The ADON stated lab results were sent to the main fax line in the facility. The ADON stated that the physician then provided medication orders and nurses had access to antibiotics in the pixus system. 33215 2. Resident 44 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included, but not limited to, acute kidney failure, diabetes mellitus type 2, anxiety disorder, essential hypertension, and UTI. Resident 44's medical record was reviewed on 9/28/22. On 7/22/22 at 4:04 PM, a Nurses Note documented LAB - Called [name of lab removed] to pick up a urine swab for the pt [patient] who thinks that she may have a UTI. Left swab and order with paperwork at the nurses station and let them know to pick it up there. They said that they will come today or tomorrow. (continued on next page)

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	465129	A. Building B. Wing	10/03/2022

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F 0690 Level of Harm - Actual harm Residents Affected - Few	On 7/22/22 at 11:14 PM, a Nurses Note documented Pt has been crying on and off throughout shift. Pt requests Ativan frequently, nurse has contacted MD multiple times, MD has not responded, nurse told pt about communication with MD, pt seems really upset and frustrated, pt said 'I hope he gets COVID [Coronavirus Disease-2019] real bad.' Pt c/o [complains of] urinary tract pain, asked for pain med [medication], asked about results of UA. Will cont [continue] to monitor throughout shift. On 7/24/22, a urinalysis report documented that resident 44 had a UTI. The common organisms detected were candida species, Enterococcus faecium, Enterococcus faecalis, Escherichia coli, and Peptostreptococcus prevotti. The report further documented the antibiotic of choice as Amoxicillian 875/125 mg by mouth twice a day for 7 days for possible acute UTI. On 7/26/22, a physician's order documented Amoxicillin-Pot [Potassium] Clavulanate Tablet 875-125 MG Give 1 tablet by mouth two times a day for UTI for 7 Days. A review of the July 2022 MAR revealed that resident 44 received the first dose of Amoxicillian on 7/27/22 at 7:00 AM. [Note: The first dose of Amoxicillin was administered three days after the UA report was received.] A review of the August 2022 MAR revealed that resident 44 did not receive a dose of Amoxicillian on 8/1/22 between 6:00 AM to 10:00 AM. [Note: Resident 44 received the last dose of Amoxicillian on 8/2/22 between 6:00 PM to 10:00 PM. Resident 44 missed one dose of Amoxicillian.] On 8/5/22 at 4:08 AM, a Nursing progress note documented Pt has been tearful for most of shift. Pt c/o R [right] abd [abdomen] pain, described as 'stretching,' guarding upon assessment, reports increased pain on laying down, passing gas, last BM 8/4 [22] AM. Pt then c/o 'kidney pain,' when nurse percussed flank, pt c/o pain. DON and provider notified, tylenol given (see emAR [electronic Medication Administration Record]), will get a UA. Pt called multiple times about Ativan, nurse said she couldn't give d/t [due to] med d/c'd [discontinued] and provider hasn't answered yet. Pt hears screaming, staff asked pt what was wrong, pt c/o bilat [bilateral] foot pain, nurse assessed, feet looked baseline, pt c/o 'feel like they are going to explode,' pt said it was d/t increased sodium in diet, nurse explained that pt was getting renal diet so this would not be the reason. Pt requested ice packs and lotion rubbed into feet, staff applied both. Pt reported treatment effective. Pt has been tearful and c/o different pains/ailments throughout shift. Provider and DON notified. [Note: A physician's order and the results of the UA were unable to be located.] On 8/6/22 at 5:37 PM, a Nursing progress note documented Pt was found calling out for people that weren't there in her room around 4pm today. I checked her vitals [vital signs]. Her oxygen was at 60, RR [respiratory rate] 18 Temp [temperature] 98 bp [blood pressure] 122/88. I put oxygen on her and it wouldn't get to 90 until I put it to about 5 Liters. I informed NP and Dr [doctor] of the facility via tiger text. There was no response back on the matter. Kept her on oxygen because when I take it off, she dips back down to below 90. She stopped calling out to unseen others after I put the oxygen on. Its almost end of shift, she is at 93 and has oxygen on. I will give this information in report at the end of shift. Lungs sounds clear in all lobes. Pt stated that even though I was giving her, her blood sugar, that she didn't feel like taking her self administered insulin. Her bs [blood sugar] around 5pm was 497. She gave me permission to give her 10 units of fast acting insulin. (continued on next page)

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	465129	A. Building B. Wing	10/03/2022

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F 0690 Level of Harm - Actual harm Residents Affected - Few	On 8/8/22 at 3:01 AM, a Nursing progress note documented 8/7/22 2200 [10:00 PM]-This Nurse called non emergency transport to send Pt to [name of hospital removed] to be evaluated d/t change in condition .such as: increase in oxygen therapy, is a feeder, edematous, and change in mentation. 2220 [10:20 PM]-EMS [Emergency Medical Services] arrived to facility 2228 [10:28 PM]-Pt left facility on Stretcher Family notified and MD 8/8/22 0217 [2:17 AM]- UPDATE- admitted to ICU [Intensive Care Unit] On 8/7/22, the hospital notes documented . The patient presents by ambulance from a nursing home with acute confusion. She is unable to provide a thorough history. Her exam is concerning for diffuse anasarca with depleted intravascular volume, including dry mucous membranes. She has a history of prior urinary tract infections. She was treated with IV [intravenous] and Rocephin shortly after arrival. Labs are notable for severe anemia. The patient also apparently has liver disease, and she has hypoalbuminemia, which could contribute to the interstitial edema. Her chemistry panel is concerning for significant elevations of the BUN [blood urea nitrogen], creatinine, and potassium. She was immediately started on treatment for hyperkalemia, including calcium gluconate, insulin and dextrose, and albuterol. I spoke with the nephrologist, who states that he knows the patient has chronic renal insufficiency, she is now in acute renal failure and will likely require dialysis. The patient will go to the ICU for emergent management of her renal failure and hyperkalemia with metabolic encephalopathy. On 8/8/22, the hospital notes documented . The patient is conversant but not oriented to year or situation. Per report, she has been having worsening confusion over the past two days. She has had a dry mouth and decreased UOP [urinary output] over this timeframe as well. She has generalized swelling. She reports nausea and vomiting over the last few days as well, and non-bloody diarrhea. She is unsure what her renal disease is from but follow with [name of doctor removed]. On 8/25/22 at 1:50 PM, a NP progress note documented . SUBJECTIVE: [Name of resident 44 removed] is seen today as a readmit. She has a medical history significant for T2DM [type 2 diabetes mellitus] on insulin, CKD [chronic kidney disease], HTN [hypertension], HLD [hyperlipidemia], and multiple wounds. She was sent to [name of hospital removed] with nausea and decreased by mouthintake [sic] where she was found to have hyperkalemia and a GFR [glomerular filtration rate]< [less than] 10. She was started on dialysis, is followed by Nephrology. On 10/3/22 at approximately 12:40 PM, an interview was conducted with RN 1. RN 1 stated that she was an agency nurse and it was her first day working at the facility. RN 1 stated she had no knowledge regarding the circumstances of resident 44's hospitalization . On 10/3/22 at 12:58 PM, an interview was conducted with the ADON. The ADON stated that resident 44 was diagnosed at the hospital with a urinary tract infection. The ADON stated when resident 44 was readmitted to the facility resident 44 had a new diagnoses of renal failure and was put on dialysis. The ADON stated that resident 44 was possibly sent out to the hospital due to a change in mental status. On 10/3/22 at 1:59 PM, an interview was conducted with the DON. The DON stated she had no knowledge regarding the circumstances of resident 44's hospitalization . On 10/3/22 at 3:43 PM, a follow up interview was conducted with the DON. The DON stated that she could not see that the UA was completed for resident 44 on 8/5/22.

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	465129	A. Building B. Wing	10/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0697 Level of Harm - Actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30563 Based on observation, interview, and record review it was determined, for 3 out of 34 sampled residents, that 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 resident's goals and preferences. Specifically, residents complained of uncontrolled pain with no interventions or physician follow up. In addition, a resident went to the hospital in pain after pain medications were adjusted. Resident identifiers: 25, 29, and 45. Findings included: 1. Resident 29 was admitted to the facility on [DATE] with diagnoses which included low back pain, injury to left lower leg, hypothyroidism, edema, chronic pain, and nausea. On 9/26/22 at 12:32 PM, an interview was conducted with resident 29. Resident 29 stated she was unable to stand her pain last night and was groaning. Resident 29 stated there was no nurse on her hallway from 12:00 AM until 6:00 AM. Resident 29 stated she needed Tramadol at 2:00 AM but the nurse told resident 29 it was not her problem because she would not be there. Resident 19 stated the nurse continued to tell her she would not be the nurse to administer the Tramadol. Resident 29 stated she had scoliosis that made a hole in her spine and she has no control over her left lower extremities. Resident 29 stated she needed her Tramadol regularly because her pain never quit. Resident 29 stated her Tramadol was not administered at 2:00 AM when she wanted it. Resident 29 stated that her pain was at a 10 and she was crying and sick to her stomach. Resident 29 stated the nurse administered three pills to her early in the morning that morning and she did not know what the medications were. Resident 29's medical record was reviewed on 9/28/22. An admission Minimum Data Set (MDS) assessemnt dated 7/14/22, revealed that resident 29 frequently experienced pain. The MDS revealed resident 29 had pain that made it hard for her to sleep at night and limited her day-to-day activities. The MDS revealed resident 29 had as needed pain medications and no scheduled pain medications. A care plan created on 9/19/22, with a problem start date of 8/1/22, revealed resident 29 was at risk for pain secondary to chronic pain. The goal was resident 29 would have no unaddressed pain, through next review. The approaches included educate resident on newly prescribed medications, monitor for side effects, medications as prescribed, monitor pain as prescribed, and other non-pharmacological approaches to pain management. A current physician's order dated 8/1/22, revealed acetaminophen 650 milligrams (mg) three times per day. A current physician's order dated 8/2/22, revealed Lidocaine adhesive patch, medicated; 5%; topical apply patch to back daily. The Medication Administration Record (MAR) for August 2022 revealed Lidocaine adhesive patch was not administered on the following dates: (continued on next page)

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	465129	A. Building B. Wing	10/03/2022

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F 0697 Level of Harm - Actual harm Residents Affected - Few	a. On 8/23/22, Drug/Item Unavailable: Could not find b. On 8/24/22, Drug/Item Unavailable c. On 8/25/22, Drug/Item Unavailable d. On 8/26/22, Drug/Item Unavailable: Notified DON [Director of Nursing] - DON is getting more e. On 8/27/22, Drug/Item Unavailable: Waiting for delivery f. On 8/28/22, Drug/Item Unavailable g. On 8/29/22, Drug/Item Unavailable A current physician's order dated 8/1/22, revealed Naprosyn (Naproxen) tablet 500 mg twice daily for lower back pain. A current physician's order dated 8/1/22, revealed Voltaren Arthritis Pain (Diclofenac sodium) gel; 1%; topical administered three times per day. The instructions were to apply to knees and ankles. The diagnosis associated with the gel was low back pain. The MAR for August 2022 revealed Voltaren gel was not administered on the following dates: a. On 8/9/22, No nurse b. On 8/30/22, Drug/Item unavailable c. On 8/31/22, Drug/Item unavailable A physician's order dated 8/1/22, revealed cyclobenzaprine tablet 5 mg oral once a day as needed for muscle spasms. A physician's order dated 8/1/22, and discontinued on 8/11/22, revealed Oxycodone 5 mg tablet every 12 hours as needed for low back pain. On 8/11/22, the oxycodone 5 mg was scheduled every 12 hours for low back pain. A physician's order dated 8/1/22, and discontinued on 8/11/22, revealed Tramadol 50 mg 2 tablets every 6 hours as needed for low back pain. The Tramadol was changed to Tramadol 50 mg 2 tablets scheduled every 12 hours on 8/11/22, and discontinued on 8/21/22. The Tramadol order was changed to 100 mg every 4 hours as needed for pain on 8/21/22, through current. Progress notes revealed the following entries: a. On 8/15/22 at 11:06 AM, the physician documented resident 29 had chronic back pain with medications listed. (continued on next page)

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	465129	A. Building B. Wing	10/03/2022

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F 0697 Level of Harm - Actual harm Residents Affected - Few	b. On 8/16/22 at 4:07 PM, resident 29 complained about pain and said that today was worse than normal and she kept up with pain medications and provided as needed pain medications. Resident 29 was unable to walk since she was at another nursing facility when she was walking and heard three pops. Resident 29 had since had pain radiating from her back into her legs. Pain was controlled with the medication she was on now. c. On 8/21/22 at 3:25 AM, PT [patient] kept complaining about pain, and requested to talk to the doctor's about her medication regimen, she feels her current regimen isn't working. Pt was extremely upset. Pt did state she was at a 9 out of 10 [pain scale] and was still able to sleep. On the 1800 [6:00 PM] - 0600 [6:00 AM] shift, the CNA's [Certified Nursing Assistant] went to do their rounds and the pt was wearing the same brief from the previous night, stamped 0425 [4:25 AM] and when the CNA changed her, there was evidence of a BM [bowel movement], but not actual BM present, the pt wasn't cleaned well, and she was upset about it. d. On 8/21/22 at 10:28 AM, Resident 29 complained of pain and was requesting to go to the hospital emergency room . Resident 19 was angry narcotics had been spaced further out and Tramadol had been discontinued. Resident 29's vital signs were taken and her as needed pain medication had been administered. The Assistant Director of Nursing (ADON) was notified and resident 19 was transferred to the hospital. e. On 8/21/22 at 11:55 AM, Resident 29 was taken by ambulance to the hospital emergency room . f. On 8/21/22 at 4:16 PM, Resident 29 returned to the facility with new orders for Tramadol 100 mg every 6 hours. g. On 8/24/22 at 12:35 PM, Resident 29 informed the nurse of the hospital situation. Resident 29 was happy to have her pain medication back. Resident 29 was frustrated that she had not gotten any results back from the hospital. An Emergency provider report dated 8/21/22 at 11:48 AM, revealed Resident 29 .presents with complaints of constellation of symptoms including right leg, right knee, and right hip pain that she has had for more than 3 months but has increased over the last day or so. She coordinates this with increasing urination and dysuria. In addition this week the patient's narcotic dose apparently was dropped in half and since that time the patient has had increasing pain in her back and legs. The patient tells me that the initial injury to her lower back was approximately 3 months ago and was worsened by her underlying scoliosis. The Discussion/Course section revealed no new fractures and The patient was aggressively treated upon arrival and underwent a full diagnostic workup. The patient did receive IV [intravenous] fluids and medications here in the department. The patient felt much better. The patient's primary concern was that she wanted to have her narcotics return back to where they were before. I talked with [physician from facility] and he will contact them back and readjust her medications back to where she had been. A Nurse Practitioner (NP) note dated 8/26/22, revealed that resident 29's Tramadol had been changed to every 12 hours and was in pain over the weekend. The NP wrote she went to the hospital to have her Tramadol increased to every 6 hours, she stated that worked much better for her. The MAR for September 2022 revealed the following: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465129	A. Building B. Wing	10/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Parkway Health Center	55 South Professional Way Payson, UT 84651

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0697 Level of Harm - Actual harm Residents Affected - Few	a. Acetaminophen 650 mg three times per day were not administered on 9/6/22, 9/7/22, and 9/8/22 because the Drug/Item was unavailable and on order. b. Lidocaine patch adhesive patch 5% topical once per day was not administered on 9/1/22, 9/2/22, 9/26/22, and 9/27/22 because the Drug/Item was unavailable and needed to order more. The MAR for September 2022 further revealed that resident 29 was administered Tramadol on 9/25/22 at 10:27 PM, and was not administered the next dose until 3:45 AM. [Note: Resident 29 stated she wanted her Tramadol around 2:00 AM and it was not administered until 1 hour and 15 minutes after the time she was allowed to have it.] On 10/3/22 at 11:57 AM, an interview was conducted with the ADON. The ADON stated if the medication was not available then it was because the pharmacy did not have a supply. The ADON stated medications like Tramadol were in the Pyxus system and he was not sure why the medication was not administered on 8/9/22, because there was always a nurse at the facility. The ADON stated when a resident was in pain and the pain medications and gels were not available, then the pain would be increased. 2. Resident 25 was admitted to the facility on [DATE] with diagnoses which included hypothyroidism, hyperlipidemia, depression, hypertension, borderline personality disorder, pain, and edema. On 9/26/22 at 12:32 PM, an interview was conducted with resident 25. Resident 25 stated she saw a physician once at the facility, who came into her room and said how are you and looked at her. Resident 25 stated she had not seen one since. Resident 25 stated she was not able to tell the physician what she needed. Resident 25 stated she had asked for a referral to the pain clinic because she needed a shot in her lower back. Resident 25 stated she had pain in her lower back and the shot really helped her pain. Resident 25's medical record was reviewed on 9/29/22. An admission MDS dated [DATE], revealed resident 25 had a Brief Interview of Mental Status score of 11 which indicated moderate cognitive impairment. The MDS further revealed that resident 25 did not have scheduled pain medication but had pain medication as needed. Resident 25 did not have non-medication interventions for pain. The MDS revealed that a pain assessment interview should be conducted and there was no pain according to the resident interview. A care plan with a problem start date of 7/19/22, and created on 7/31/22, revealed resident 29 was at risk for pain secondary to limited mobility. The goal was resident 25 would not have any unaddressed pain through the next review. The approaches included education on new prescribed medications, monitor for side effects, medications as prescribes, monitor pain as prescribed, and offer non-pharmacological approaches to pain management. A physician's note dated 8/15/22 at 10:35 AM, revealed resident 25 had chronic back pain and to refer to a local pain clinic physician. Resident 25 wished to continue to be treated with her back pain at a pain clinic. Otherwise her medical conditions were well controlled at this time. An NP note dated 9/1/22 at 7:16 AM, revealed [Resident 25] is seeing today to follow up on her back and lake (sic) pain. She states that she still would like to see a physician who could do injections to her back as she states she will have weakness in her lower extremities. (continued on next page)

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	465129	A. Building B. Wing	10/03/2022

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F 0697 Level of Harm - Actual harm Residents Affected - Few	An NP note dated 9/21/22 at 3:52 PM, revealed, Subjective: [Resident 25] is seen today for a follow up visit. She states she continues to have pain in her back, appointment with pain specialist is pending. She denies any increased numbness or tingling to her lower extremities. The treatment plan was Chronic Pain Syndrome - Continue Tylenol - Refer to spinal interventions or similar for spinal injections. An NP note dated 9/27/22 at 8:05 AM, revealed SUBJECTIVE: [Resident 25] is in today at her request wanting to follow up on an appointment for spinal injections. Discuss this with facility staff, who have been working to make appointments. She said she has done this for many years, and reports that it helps so that she can ambulate better. She reports she would still like to pursue this. The treatment plan was Chronic Pain Syndrome - Continue Tylenol - Refer to spinal interventions or similar for spinal injections. Progress notes revealed the following entries regarding resident 25 complaining of pain: a. On 8/5/22 at 11:22 AM, resident 25 experiencing back pain from physical therapy. Administered 400 mg of ibuprofen. b. On 8/16/22 at 4:05 PM, resident 26 complaining often of back and hip pain, worried that she would not be able to go to the pain clinic. Resident 25 was counseled that the physician was working on getting her to a pain clinic. Resident 25 had chronic pain treated by another pain clinic in another city. c. On 8/24/22 at 12:55 PM, resident 25 continues to complain of back and hip pain but ointment seems to help when applied. Resident 25 was having a hard time reaching things off the floor because of her keen pain. The MAR for September 2022 revealed pain monitoring twice daily. The pain scale was 0 to 8 with non-pharmacological interventions documented. On 9/28/22 at 9:25 AM, an interview was conducted with Registered Nurse (RN) 3. RN 3 stated resident 25 had Diclofenac Sodium for topical cream application. RN 3 stated she applied the cream to resident 25. On 9/28/22 at 10:00 AM, an interview was conducted with Restorative Nursing Assistant (RNA) 1. RNA 1 stated resident 25 complained of pain and preferred to use a walker because her knees and ankles gave out when she walked. RNA 1 stated resident 25 had pain in her knee and had complained maybe two to three times to her about pain. On 10/3/22 at 12:10 PM, an interview was conducted with the ADON. The ADON stated resident 25 complained of back pain and had a pain cream for her back. The ADON stated that resident 25 did not have other pain medications but nurses had standing orders for Tylenol that she could have every 6 hours. The ADON stated there should be information regarding standing orders in an Agency binder at the nurses station to inform agency staff. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	On 10/3/22 at 2:29 PM, an interview was conducted with the Director of Nursing (DON). The DON stated that resident 25 did not have an appointment with a pain clinic. The DON stated that the transportation director was trying to get an appointment at the pain clinic but had not been able to. 38031 3. Resident 45 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included major depressive disorder, adult failure to thrive, abdominal pain, hydroureter, anemia, opioid dependence, and anxiety disorder. On 9/26/22 at 10:57 AM, an interview was conducted with resident 45. Resident 45 stated that she had pain in the left foot. Resident 45 stated that she wrapped the foot herself with an ace bandage to help alleviate the pain. Resident 45 stated that the foot pain had been present since May. Resident 45 also reported chronic pain all over her body with diagnoses of fibromyalgia and complex regional pain syndrome. Resident 45 appeared calm, no facial grimacing noted, and no outward signs and symptoms of pain were noted. Resident 45 never stated their current pain score when asked multiple times. Resident 45 stated that they were taking gabapentin, Norco 5 mg every 6 hours, and a non-steroidal anti-inflammatory drug for pain relief. Resident 45 stated that they had their pain managed by an outside provider at a pain clinic. Review of resident 45's physician orders revealed: a. Acetaminophen tablet 325 mg, give 2 tablets (650 mg) by mouth every 6 hours as needed (PRN) for pain - Not to Exceed 3 gram in 24 hours from all sources. The order was initiated on 8/1/22. b. Butrans (buprenorphine) - Schedule III patch, apply 20 micrograms (mcg)/hour (hr) transdermal patch once a week. Take one transdermal patch to a different site each week prn pain. Remove old patch before applying new one. Special Instructions: per pain clinic [name of provider] will be in charge of controlling and refilling all pain medication. The order was initiated on 9/2/22. c. Endocet (oxycodone-acetaminophen) tablet 10-325 mg, give 10-325 mg by mouth every 4 hours PRN for pain. Special Instructions: per pain clinic [name of provider] will be in charge of controlling and refilling all pain medication. The order was initiated on 8/30/22. d. Gabapentin tablet 600 mg, give one tablet by mouth three times a day. Special Instructions: per pain clinic [name of provider] will be in charge of controlling and refilling all pain medications. The order was initiated on 9/2/22. e. Meloxicam tablet 7.5 mg, give one tablet by mouth one time a day. Special Instructions: per pain clinic [name of provider] will be in charge of controlling and refilling all pain medications. The order was initiated on 9/3/22. (continued on next page)

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	465129	A. Building B. Wing	10/03/2022

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F 0697 Level of Harm - Actual harm Residents Affected - Few	Review of resident 45's September 2022 MAR revealed the Butrans 20 mcg patch weekly was not administered on 9/7/22, 9/14/22, 9/21/22, 9/28/22 and was documented as Not Administered: Drug/Item Unavailable. It should be noted that the Butrans patch was not available the entire month of September, and resident 45 did not have one dose administered since the medication was ordered. The Endocet 10-325 mg every 4 hours was administered 147 times out of 174 opportunities during September 2022. The Endocet was documented as somewhat effective for 14 of the documented administrations, and 31 of the documented administrations were for left foot pain. Review of resident 45's progress notes revealed the following: a. On 6/27/22 at 6:39 AM, the note documented, Narcotics were found in pts [patients] room. Pt states that they are the norco that was administered by NOC [night] shift this morning. Nurse verified that they were norco. Pt stated that she was refusing to take the norco until she got her alprazolam. Administered both norco and alprazolam per MD [Medical Director] orders. b. On 7/1/22 at 5:59 PM, the note documented, Pt. constantly complaining telling staff that she is upset that her MRI [magnetic resonance imaging] on her L [left] foot was cxl [canceled] even after nurse explained twice why it was. Notified pt. that hospital was called, note was sent to physician in box and waiting for clinical note to be filled out. Pt. also asked for print out of all her meds [medications]. Was given. She requests physician to see her to change pain meds because they are not working. c. On 7/8/22 at 12:24 PM, the note documented, Walked in the room to give the patient her noon meds. Pt. stated she is upset that she is on Clonazepam for anxiety instead of Alprazolam. She is also upset that she has still not had her MRI. Her and her mother stated that they feel that we are not working on doing what we need to do to take care of her foot. I told her that we are doing everything we can to get an MRI approved through the insurance and scheduled. They stated that they don't believe that we are. I assured her that we are doing everything to care for her needs. d. On 7/9/22 at 2:25 PM, the note documented, I called [name of pharmacy] to follow up on the patients Norco RX [prescription]. They told me that they accidentally made a discrepancy with the amount that they put in the computer for that medication. They said that they would text the DON of the facility and explain the mistake that they made on their end. They said that they would charge the facility until they can straighten out the error with the patients insurance and then refund us for what they change (sic) us on this medication. They will send it to us asap [as soon as possible]. e. On 7/10/22 at 1:35 PM, the note documented, Pulled two norco from the pixus while waiting on order from the pharmacy to come through. f. On 8/10/22 at 7:56 PM, the note documented, pt still refusing all meds except narcotics and gabapentin, copies made of mri report from august 4, 2022 dx [diagnosis] of well defined 3 cm [centimeter] hemangioma in left foot and biopsy to be scheduled, pt states another follow up end of this week (continued on next page)

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	465129	A. Building B. Wing	10/03/2022

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	465129	A. Building B. Wing	10/03/2022

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F 0697 Level of Harm - Actual harm Residents Affected - Few	m. On 8/30/22 at 10:52 AM, the note documented, The pt's pain clinic nurse called me this morning at 0830 [8:30 AM], and told me that i needed to give the pt her gabapentin 3x [times] a day, and her meloxicam 1x a day. Went and talked to [DON name omitted], because I was unsure of what was going on, [DON name omitted], informed me, [NP name omitted] stopped all prescriptions due to the changed medication regimen. [DON name omitted], advised me to call the pain management clinic and get written orders, then let [NP name omitted] review them and decide whether or not they should be added to the pt's current medication regimen. Called [pain provider's name] clinic and asked to speak to him, or one of the nurses, and they were all in clinic and unavailable. I left a message with [receptionist name omitted], the receptionist, that I need written orders for the facilities (sic) provider to review. n. On 9/2/22 at 4:00 PM, the note documented, Spoke w/ [with] [name of pharmacy] per pt. request to see why Butran patches had not arrived, and to get gabapentin and meloxicam back. Facility physician states pt. needs to go through pain clinic. Tried calling [name of] Pain clinic about meds and they were closed . states they were supposed to get a prior auth [authorization] for Butran and instead d/c it. Notified them of the written order and put it back in computer. They stated it was reactivated on their side as well. notified pt. of status. o. On 9/8/22 at 8:38 AM, the NP note documented, . is seen today to follow up on her anxiety and depression. She is laying in bed, said she's waiting for her Percocet. All of her pain management is now being completed by [name of pain provider omitted], who manages her Percocet, gabapentin, meloxicam, and any other pain related medication. She asked me today about getting a Butrans patch, again explain to her that this would have to be approved through [name of pain provider]. She states that her anxiety has been improved since she started back on her pain medication, she also states her depression is better. Resident 45's pain scores for August 2022 were reviewed. Out of 126 recorded pain scores, on a scale from 1 to 10, the resident averaged a score of 8 out of 10. No documentation could be found of a pain assessment for resident 45. On 9/26/22, a care plan for chronic pain was initiated. Interventions identified were educate the resident on newly prescribed medications; monitor for side effects of pharmacological pain interventions and notify physician; monitor pain as prescribed; and offer non-pharmacological approaches to pain management. On 9/27/22 at 10:22 AM, an interview was conducted with RN 4. RN 4 stated that she was an agency nurse. RN 4 stated that this was her first full shift at the facility and she had worked one other time for half a shift. RN 4 stated that she had noticed that all the staff today were agency. On 9/27/22 at 1:28 PM, a follow-up interview was conducted with RN 4. RN 4 stated that when she came on shift she was handed a piece of paper to write down any medications that were out of stock. RN 4 stated that she was not informed of the process for ordering medication for a resident. RN 4 stated that she thought the facility had a Pyxis machine, that is how it is at all the facilities. RN 4 stated that she did not have an access code for the Pyxis dispensary, only the facility nurses were granted access. RN 4 stated that she had not been provided any instructions at this facility. (continued on next page)

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	465129	A. Building B. Wing	10/03/2022

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F 0697 Level of Harm - Actual harm Residents Affected - Few	On 9/27/22 at 10:03 AM and again at 1:57 PM, an interview was conducted with Licensed Practical Nurse (LPN) 1. LPN 1 stated that she was an agency nurse, and had worked at the facility prior to becoming an agency staff. LPN 1 stated that if medications were running low they would order them from the pharmacy. LPN 1 stated that when the blister pack had only the last row or column remaining she would pull the reorder sticker and place on the refill sheet, or check to make sure that it was not too early to refill the medication. LPN 1 stated that she had the ability to reorder some medications through the electronic medical records, but not for all residents. LPN 1 stated that she could also fax the order to the pharmacy. LPN 1 stated that she could also call the pharmacy with any orders. LPN 1 stated a Pyxis was available to pull medication from, and that she had the ability to access the Pyxis. LPN 1 stated that if medications were not available she would document in the MAR, and include a note that stated she contacted pharmacy. LPN 1 stated that medications would usually arrive at the facility the same day if it was scheduled for a refill, they will put it on the next run. LPN 1 stated sometimes if the medication was not due to be reordered then it would not be refilled. LPN 1 stated that occasionally medications were misplaced or located in another cart and she would have to locate the medication to administer it. On 9/27/22 at 2:40 PM, an interview was conducted with the DON. The DON stated that the process for reordering medication was to pull the reorder stickers from the blister pack, order through the electronic medical records, or call the pharmacy directly. The DON stated that the electronic medical records reorder was available for all residents, and that they had been training the agency staff on reordering medication for the last two weeks. The DON stated that medications were available in the Pyxis system, but not all staff had access to the medication dispensing system. The DON stated that the pharmacy was coming out this week to give access to all licensed nurses at the facility, including the agency staff. The DON stated that there was usually a nurse at the facility that had Pyxis access and the ADON lived nearby and could run over to get medication from the Pyxis for staff. The DON stated that since she had been at the facility, which was the last two weeks, she had made sure that someone was on shift who had access to the Pyxis. The DON stated that staff should contact the pharmacy to obtain a refill, and notify the provider if a medication was not administered. The DON stated that the documentation was located on the MAR or in a progress note. The DON stated that the pharmacy had three deliveries a day and they were very responsive. The DON stated that she had worked a couple of shifts and the pharmacy had medication delivered within two hours yesterday. The DON stated that the licensed nurses should contact the pharmacy to obtain a refill or contact the provider to obtain a new prescription. (continued on next page)

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	465129	A. Building B. Wing	10/03/2022

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F 0697 Level of Harm - Actual harm Residents Affected - Few	On 10/3/22 at 11:04 AM, an interview was conducted with the ADON. The ADON stated that resident 45 had her own pain provider. The ADON stated that when resident 45 was first admitted , the facility provider was managing the pain medications. The ADON stated that resident 45 did not like the regimen provided by the facility physician so she went to her own pain clinic provider. The ADON stated that the pain clinic provider would send the pain medication orders to the facility for them to administer. The ADON stated that the pain clinic provider ordered Percocet and Gabapentin for resident 45. The ADON stated that he was not familiar with the Butrans patch. The ADON stated that once they received the order they sent it directly to the pharmacy. The ADON stated that the coordination of care for resident 45's pain management was to call the pain clinic directly to ask questions. The ADON stated that the facility providers wanted the staff to refer to the pain clinic provider for resident 45's pain medication management. The ADON stated that if a medication needed a prior authorization, such as the Butrans, they should have contacted the pain clinic for the authorization. The ADON stated that documentation of the communication with the pain clinic should be in a progress note. The ADON stated that staff should have documented any communication with the pain clinic, and if it was not authorized for any reason then they should have the documentation for that.

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	465129	A. Building B. Wing	10/03/2022

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33215 Based on interview and record review, it was determined, the facility did not ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the resident's goals and preferences. Specifically, for 1 out of 34 sampled residents, a resident who was receiving dialysis services did not have a physician's order for dialysis services or monitoring of the fistula. The resident did not receive ongoing assessments and oversight before and after dialysis treatments. In addition, ongoing communication and collaboration with the dialysis facility regarding the residents dialysis care and services was not completed by facility staff. Resident identifier: 44. Findings included: Resident 44 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included, but not limited to, acute kidney failure, diabetes mellitus type 2, anxiety disorder, essential hypertension, and urinary tract infection. On 9/26/22 at approximately 10:00 AM, an interview was conducted with the Director of Nursing (DON). The DON stated that resident 44 would be leaving the facility soon for dialysis. The resident Matrix For Providers was provided by the facility upon entrance and was reviewed. Resident 44 was not checked for receiving Dialysis services. Resident 44's medical record was reviewed on 9/28/22. On 8/23/22, the Discharge Summary from the hospital documented that resident 44 had end stage renal disease. A temporary dialysis catheter was placed on admission and a tunneled dialysis catheter was placed on 8/15/22. Resident 44 continues on scheduled hemodialysis per Nephrology. The Discharge Instructions included, but not limited to, hemodialysis per Nephrology orders. Tunneled hemodialysis catheter care per Nephrology. Discharge to Skilled Nursing Facility. On 8/24/22 at 9:05 AM, an Admission Assessment and Skin Check was reviewed. The form was blank. An Admission Minimum Data Set assessment dated [DATE], did not document that resident 44 was receiving dialysis services while not a resident and while a resident. The August 2022 Medication Administration Record (MAR) was reviewed. There were no physician's orders documenting that resident 44 was receiving dialysis. On 8/25/22 at 1:50 PM, a Nurse Practitioner (NP) progress note documented . SUBJECTIVE: [Name of resident 44 removed] is seen today as a readmit. She has a medical history significant for T2DM [type 2 diabetes mellitus] on insulin, CKD [chronic kidney disease], HTN [hypertension], HLD [hyperlipidemia], and multiple wounds. She was sent to [name of hospital removed] with nausea and decreased by mouthintake [sic] where she was found to have hyperkalemia and a GFR [glomerular filtration rate]< [less than] 10. She was started on dialysis, is followed by Nephrology. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465129	A. Building B. Wing	10/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Parkway Health Center	55 South Professional Way Payson, UT 84651

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/29/22 at 10:02 AM, a NP progress note documented . SUBJECTIVE: [Name of resident 44 removed] is seen this morning to followup on her renal failure and weakness. She has been participating in physical therapy and is continuing dialysis. On 9/3/22 at 8:33 PM, a Dietary progress note documented INITIAL [Name of resident 44 removed] is here with AKF [acute kidney failure], UTI [urinary tract infection], hyperlipidemia, DM2 [diabetes mellitus type 2], and anxiety. Diet order is Renal,CCHO [Consistent Carbohydrate Diet]/Regular consistency. Meal intakes are good with mostly 76-100%. She is going to dialysis 3x [times]/week at [name of dialysis center removed]. I called [name of dialysis center removed] to obtain most recent dry weight and labs [laboratory], although they have not taken any labs for her yet; they will be available at the end of next week. I adjusted her weight for obesity. She is taking a renal vitamin. When I visited with her, she stated that her eating and appetite are okay. She states she is allergic to artificial sweeteners. I gave her some papers with information about foods high and low in sodium, potassium, and phosphorus so she can more easily make food choices that will keep her levels WNL [within normal limits]. Will recommend that she is weighed weekly for the first four weeks, then monthly after that. I will also continue to monitor labs [laboratory] as they are available at the dialysis center. [Note: Lab results were unable to be located in the medical record. Resident 44 was not weighed weekly for the first four weeks as recommended.] Resident 44's vital signs for Weight were reviewed. The following were documented: a. On 9/14/22 at 4:49 PM, 252.5 pounds. b. On 9/17/22 at 9:32 AM, 252 pounds. A care plan Problem created on 9/3/22, documented Category: Nutritional Status [Name of resident 44 removed] is at risk for nutritional deficits secondary to morbid obesity and need for dialysis. A care plan Goal created on 9/3/22, documented Long Term Goal Target Date: 12/03/2022 [Name of resident 44 removed] will not experience any untreated weight variances through next review. The care plan interventions created on 9/3/22, included: a. Assist with dental appliances; provide dental supplies; Make dental referrals, as needed. b. Diabetic medication and treatments as prescribed. c. Dietitian and nutritional assessment or evaluation, as needed. d. Honor food preferences. e. If resident 44 was not satisfied with the meal, offer alternative meal. f. Monitor blood glucose levels as prescribed. g. Monitor, document, and report signs or symptoms of dysphagia: pocketing; choking; coughing; drooling; holding food in mouth; several swallowing attempts; refusing to eat; concerned appearance during meals. (continued on next page)

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	465129	A. Building B. Wing	10/03/2022

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	h. Obtain labs and monitor as prescribed. i. Provide diet and snacks as prescribed. j. Weight monitoring as prescribed. On 9/12/22 at 6:59 AM, a NP progress note documented . SUBJECTIVE: ., she has dialysis today. On 9/20/22 at 2:18 PM, a Nursing progress note documented [Name of resident 44 removed returned from a Left arm AV [arteriovenous] fistula surgery today around 1:45pm. Res. [Resident] has ACE [all cotton elastic] bandage on surgical site that is to be left on for 48hrs [hours]. Fistula should be auscultated for bruit and thrill. Was last given Norco at 12:40pm by hospital. The September 2022 MAR was reviewed. There were no physician's orders documenting that resident 44's fistula should be auscultated for bruit and thrill. On 9/28/22 at 11:27 AM, an interview was conducted with Registered Nurse (RN) 2. RN 2 stated that she was told that resident 44 was receiving dialysis for renal failure. RN 2 stated that resident 44 went to dialysis on Monday, Wednesday, and Friday each week. RN 2 stated that resident 44 had a physician's order in the medical record for dialysis. RN 2 stated that the facility Transportation would keep a record of each resident on dialysis and post the appointments weekly. RN 2 stated the resident's on dialysis were on the report sheet and the information was passed on in report. RN 2 stated a resident on dialysis had daily monitoring to check for bruit and thrill of the fistula and any signs and symptoms of infection. RN 2 stated that she had never changed resident 44's dressing. RN 2 stated the monitoring and dressing change would be documented on the MAR. RN 2 stated that all residents received monthly weights and if ordered by the physician the resident would receive weekly weights. RN 2 stated if a resident was on diuretic medications the resident would receive daily weights. RN 2 stated that all residents got a full set of vital signs twice a day. RN 2 stated that resident 44 was on a 2000 milliliter a day fluid restriction. RN 2 stated the fluid restriction would be documented on the MAR and the Certified Nursing Assistants would chart the fluid restriction also. RN 2 stated if there was a problem or question she would call the dialysis center or the dialysis center would call the facility. RN 2 stated there was a dialysis book that each resident had that contained the pre-dialysis and post-dialysis notes. RN 2 stated the floor nurses did not create care plans. RN 2 stated the DON and the administration would complete their individual assessments of the resident. [Note: The August and September 2022 MAR was reviewed. There were no physician's orders documenting that resident 44 was on a fluid restriction.] On 9/29/22 at 8:12 AM, an interview was conducted with resident 44. Resident 44 stated that she could not remember when she started dialysis. Resident 44 stated that she did not have a dialysis binder that she took with her to the dialysis center. On 9/29/22 at 8:17 AM, an interview was conducted with Licensed Practical Nurse (LPN) 1. LPN 1 stated that resident 44 had been going to dialysis as long as LPN 1 had been working with resident 44 at the facility. LPN 1 stated usually there was a binder and usually transportation would bring the paper for LPN 1 to sign and complete prior to resident 44 going to dialysis. LPN 1 stated that since this surveyor brought up the form, transportation had not been bringing LPN 1 the form to complete. LPN 1 stated that she was surprised the dialysis clinic had not made a big deal about not receiving the form. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465129	A. Building B. Wing	10/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Parkway Health Center	55 South Professional Way Payson, UT 84651

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/29/22 at 9:55 AM, an interview was conducted with the Transportation staff member. The Transportation staff member stated that when she reported to work at the facility she would ask the resident if they were going or would like to go to dialysis that day. The Transportation staff member stated she would remind the resident of their dialysis time and would take the resident to dialysis. The Transportation staff member stated that prior to leaving the dialysis clinic she would weigh the resident because weights were important. The Transportation staff member stated that she did not take any paper work with her prior to leaving the facility for dialysis or returning. The Transportation staff member stated that in the past she would take paper work with her to the resident's dialysis appointment but the prior DON told her that she did not need to do that. The Transportation staff member stated that the dialysis clinic would document on the paper work she brought back to the facility any new physician orders or what was happening with the resident. The Transportation staff member stated she would also take a list of the residents medications to the dialysis clinic. The Transportation staff member stated that she took the form once to the dialysis clinic and the prior DON told her that she did not need the form because the residents go to dialysis so frequently. The Transportation staff member stated that she quit taking the form and was only doing what she was told to do. The Transportation staff member further stated that she did not feel like that should be the process. On 9/29/22 at 10:33 AM, an interview was conducted with the DON. The DON stated there was a transportation form that was to be sent with the resident to dialysis. The DON stated that the dialysis clinic would send back the form with new orders or communication regarding the resident. The DON stated the facility had a transportation form but the DON was not sure if staff were using the form. The DON stated if a resident was receiving dialysis there should be a physician's order. The DON stated the care plan should include items for transportation, and anything specific to the resident that they would want outside of medication. The DON stated that vital signs and weights should be done on the resident. The DON stated that she was not sure what resident 44's physician's orders were for weights and the DON thought resident 44 was on daily weights. [Note: Resident 44 had two documented weights in the medical record.] On 10/3/22 at 12:58 PM, an interview was conducted with the Assistant Director of Nursing (ADON). The ADON stated that resident 44 was diagnosed at the hospital with a urinary tract infection. The ADON stated when resident 44 was readmitted to the facility resident 44 had a new diagnoses of renal failure and was put on dialysis.

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	465129	A. Building B. Wing	10/03/2022

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F 0725 Level of Harm - Actual harm Residents Affected - Few	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30563 Based on observation, interview, and record review, it was determined, the facility did not have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. Specifically, for 13 out of 34 sampled residents, resident's complained of not having enough staff to meet there needs, staff complained there were not enough staff to complete their job duties, residents laboratory (lab) results were not followed up with after a urinalysis (UA) was completed, showers were not completed, residents administered their own medications because there were not enough staff, there were no grievances, residents sustained falls, resident's complained of pain, and medications were not administered according to physician's orders. Resident identifiers: 1, 7, 8, 16, 22, 23, 25, 29, 36, 38, 45, 53, and 156. Findings included: 1. On 9/29/22 at 11:00 AM, an interview was conducted with Registered Nurse (RN) 3. RN 3 stated when a lab value or UA was ordered, she would contact the Nurse Practitioner (NP), an order was placed in the residents electronic medical record, and the lab company was contacted. RN 3 stated that the results of the laboratory were faxed to the facility or the lab contacted the NP. RN 3 stated that sometimes the lab did not send results so the nurse had to follow up with the lab. RN 3 stated if the nurse who ordered the labs was gone for a week the nurse on shift may not be aware of what labs had been ordered and which results had been sent to the facility. RN 3 stated the lab process had resulted in missed lab results. RN 3 stated that she tried to document in the progress notes when a lab was obtained. RN 3 stated on 8/19/22, she obtained a UA for resident 29 because she was probably acting confused or had a symptom like pain or burning when urinating. RN 3 stated she did not know if the physician was notified of the UA results. RN 3 stated she did not know if there was follow up because if it was not written in the medical record it was not done. RN 3 observed the UA results from 8/19/22, and stated it was a 6 on a scale of 1 to 7 which indicated resident 29 had an infection. RN 3 stated the results revealed resident 29 had a urinary tract infection that needed to be treated with Macrobid. RN 3 stated that things get very busy and I forget to get everything done. RN 3 stated there were not enough staff in the building. RN 3 stated there needed to be a nurse for each hallway because it's just crazy. RN 3 stated It's so stressful for me, because at the end of the day I sent the order and did not follow up on it and did not get treatment. RN 3 stated there were so many things to do and follow up on and with almost 40 residents it was impossible to get everything done. RN 3 stated that charting did not get done. [Cross Reference F690 and F773] 2. On 9/26/22 at 10:31 AM, an interview was conducted with resident 22. Resident 22 stated that her shower days were every Tuesday, Thursday, and Saturday. This surveyor observed a sign in resident 22's room with the posted shower days. Resident 22 stated that sometimes she did not get showered due to there not being enough staff. (continued on next page)

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	465129	A. Building B. Wing	10/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Parkway Health Center	55 South Professional Way Payson, UT 84651

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F 0725 Level of Harm - Actual harm Residents Affected - Few	On 9/26/22 at 12:32 PM, an interview was conducted with resident 25. Resident 25 stated she should get a shower today, but did not get one because staff did not show up. Resident 25 stated she got a shower on 9/24/22, but did not have one for two weeks prior to that. Resident 25 stated she took showers by herself because she became very disgusted by herself. On 9/29/22 at 12:34 PM, an interview was conducted with CNA 7. CNA 7 stated that the facility was short on staff. CNA 7 stated that she had seven showers to complete today with two CNAs on the 100 and 200 hallway. CNA 7 stated that five of the seven residents were a two person extensive assistance. CNA 7 stated that the 100 and 200 hallway did not have a shower CNA and sometimes the showers got missed. CNA 7 stated that two showers had been completed today and one resident refused. CNA 7 stated that her goal was to get three showers completed each day. CNA 7 stated if a shower was missed she would pass it on in report and see if the next shift could complete the showers. CNA 7 if the next shift could not the showers completed she would try and complete the showers the next day. CNA 7 stated that resident 22 was a set up for showers. CNA 7 stated that after she set resident 22 up for a shower she would leave and give resident 22 privacy. CNA 7 stated that resident 22 needed assistance to wash her back and get dressed. CNA 7 stated that resident 22 was very involved in her care. CNA 7 stated that the shower sheets were getting missed because a lot of the staff did not know that they had to complete a shower sheet. CNA 7 further stated that the shower book did not have any shower sheets available and staff did not have a master copy to make copies. CNA 7 stated that she had a hard time answering resident call lights when there were only two CNAs staffed because most of the residents were a two person assistance. CNA 7 further stated the willingness of other staff to answer call lights was also a concern. [Cross Reference F676] 3. On 9/26/22 at 12:32 PM, an observation was made of resident 25. Resident 25 had an inhaler in a box on her over bed table. Resident 25 was interviewed. Resident 25 stated she needed the inhaler off and on. Resident 25 stated she had the inhaler in her purse and brought it out so she had it when she needed it. Resident 25 stated she could not rely on staff to provide the inhaler when she needed it because there were not enough staff. [Cross Reference F554] 4. The grievance log was reviewed. There was a grievance dated 5/2/22, regarding call lights. There were two grievances dated 9/12/22, regarding call lights not being answered and meal cards not being followed. There were no grievances between 5/3/22 through 9/12/22. The Administrator provided Resident Council Minutes dated 4/5/22, 5/3/22, 6/7/22, 7/12/22, 8/2/22, and 9/12/22. The Resident Council Minutes dated 9/12/22, revealed long call light times and there was no follow-up documented. On 10/3/22 at 9:49 AM, an observation was made of resident 16 talking to Physical Therapy Assistant (PTA) 1 and Occupational Therapist (OT) 1. Resident 16 stated the facility was so short staffed on Saturday night that a CNA came in and told him she did not have time to change him. Resident 16 stated a nurse came in later and he told the nurse that if he was not changed, he would call the police. Resident 16 stated he told staff it was their choice on what he did. Resident 16 stated the CNA came in and changed him very quickly. Resident 16 stated he hated to be that kind of a guy, but he had no other choice. Resident 16 stated he was looking at other facilities because of staffing. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465129	A. Building B. Wing	10/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Parkway Health Center	55 South Professional Way Payson, UT 84651

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F 0725 Level of Harm - Actual harm Residents Affected - Few	On 10/3/22 at 12:31 PM, an interview was conducted with PTA 1. PTA 1 stated she did not remember talking to resident 16. After being reminded of the conversation, PTA 1 stated that resident 16 stated there was one CNA and one nurse working. PTA 1 stated resident 16 was worried because he had to teach the CNA how to use the Hoyer lift to transfer him. PTA 1 stated resident 16 said when it got to the point that he did not feel safe he would call the police. PTA 1 stated resident 16 said he needed to have a brief change, and someone went in to change him but said they needed to come back. PTA 1 stated that resident 16 said the nurse came into his room and he told the nurse if he did not get changed, he would call the police. PTA 1 stated she had not reported the information to management. PTA 1 stated she was planning on talking to the Director of Nursing (DON) about it. On 10/3/22 at 12:31 PM, an interview was conducted with OT 1. OT 1 stated that resident 16 claimed that every time that he had a new CNA working with him, the CNA did not know how to transfer him. OT 1 stated if resident 16 was not in the exact right spot then he did not think the CNA knew what they were doing. OT 1 stated some of resident 16's complaints might be warranted. OT 1 stated resident 16 was very sensitive to any new staff. OT 1 stated there had been times when staffing was poor over the weekends, and it feeds into the fact that it had not been fixed and might not be going away. OT 1 stated he usually talked to the Resident Advocate (RA), DON, and Administrator and the concerns were discussed in the morning meeting throughout the day. [Cross Reference F585] 5. On 9/26/22 at 2:33 PM, an interview was conducted with resident 53. Resident 53 stated he was transferring from the wheelchair to bed and his ankle gave out and he fell to the ground. Resident 53 stated his left shoulder always hurts but it hurt more since the fall. Resident 53 stated he was waiting for staff but staff did not come. Resident 53 stated he waited for 15 to 20 minutes and was tired from returning from a doctors appointment so he transferred himself. Resident 53 stated it took 20 to 30 minutes for someone to come and he did not want to wait. On 9/28/22 at 9:45 AM, an interview with CNA 2 was conducted. CNA 2 stated that there was not enough staff at the facility to prevent residents from falling. CNA 2 stated that the facility often staffed two or three CNAs for the entire building, which was not enough to adequately supervise residents who were a fall risk. CNA 2 stated that in addition to not having enough staff, communication between nurses and CNAs was lacking, and CNA's were often not aware if resident were a fall risk. On 9/28/22 at 10:00 AM, an interview with CNA 8 was conducted. CNA 8 stated that on some shifts there were only two CNAs in the facility. CNA 8 stated that the facility needed more CNAs to supervise residents who were a fall risk because there was not enough staff to prevent residents from falling. On 10/3/22 at 11:26 AM, an interview was conducted with CNA 9. CNA 9 stated there was a CNA chart that had which residents fell and which residents were a high fall risk. CNA 9 stated the residents had signs inside their rooms and it was in the electronic charting system. CNA 9 stated she had no idea how Agency staff knew a residents transfer status or if the resident was a fall risk. CNA 9 stated Agency had a binder but she did not know what was in the binder. CNA 9 stated resident 53 required one person assistance with transfers, bed mobility, and showering. CNA 9 stated there was no reason that three people would be providing bed mobility. [Cross Reference F689] (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465129	A. Building B. Wing	10/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Parkway Health Center	55 South Professional Way Payson, UT 84651

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F 0725 Level of Harm - Actual harm Residents Affected - Few	6. On 9/26/22 at 10:47 AM, an interview was conducted with resident 45. Resident 45 stated she had a seizure and was transferred to the hospital. Resident 45 stated that she was having issues with staffing, and getting assistance. Resident 45 stated that she had a stress induced seizure. Resident 45 also stated that she had pain in the left foot. Resident 45 stated that she wrapped the foot herself with an ace bandage to help alleviate the pain. Resident 45 stated that the foot pain had been present since May. Resident 45 also reported chronic pain all over her body with diagnoses of fibromyalgia and complex regional pain syndrome. On 9/26/22 at 12:32 PM, an interview was conducted with resident 29. Resident 29 stated she was unable to stand her pain last night and was groaning. Resident 29 stated there was no nurse on her hallway from 12:00 AM until 6:00 AM. Resident 29 stated she needed Tramadol at 2:00 AM but the nurse told resident 29 it was not her problem because she would not be there. Resident 19 stated the nurse continued to tell her she would not be the nurse to administer the Tramadol. Resident 29 stated she had scoliosis that made a hole in her spine and she has no control over her left lower extremities. Resident 29 stated she needed her Tramadol regularly because her pain never quit. Resident 29 stated her Tramadol was not administered at 2:00 AM when she wanted it. Resident 29 stated that her pain was at a 10 and she was crying and sick to her stomach. Resident 29 stated the nurse administered three pills to her early in the morning that morning and she did not know what the medications were. [Cross Reference F697] 7. On 9/26/22 at 10:32 AM, an interview was conducted with resident 22. Resident 22 stated that staff were not bringing her medications timely. Resident 22 stated that she would ask for her anxiety medication and it would take along time for the staff to bring the medication. Resident 22 stated the staff would tell her there was only one nurse. Resident 22 stated that some staff were better than others. Resident 22 stated that she did not always get her diabetic medications before meals. On 9/26/22 at 12:32 PM, an interview was conducted with resident 29. Resident 29 stated she was unable to stand her pain last night and was groaning. Resident 29 stated there was no nurse on her hallway from 12:00 AM until 6:00 AM. Resident 29 stated she needed Tramadol at 2:00 AM but the nurse told resident 29 it was not her problem because she would not be there and there was not a nurse to administer the medication. Resident 29 stated she had scoliosis that made a hole in her spine and she had no control over her left lower extremities. Resident 29 stated she needed her Tramadol regularly because her pain never quit. Resident 29 stated her Tramadol was not administered at 2:00 AM when she wanted it. Resident 29 stated that her pain was at a 10 and she was crying and sick to her stomach. Resident 29 stated the nurse administered three pills to her early that morning and she did not know what the medications were. [Cross Reference F755 and F757] (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465129	A. Building B. Wing	10/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0725 Level of Harm - Actual harm Residents Affected - Few	8. On 10/3/22 at 11:26 AM, an interview was conducted with CNA 9. CNA 9 stated there was a CNA chart that had which residents fell and which residents were a high fall risk. CNA 9 stated the residents had signs inside their rooms and it was in the electronic charting system. CNA 9 stated she had no idea how Agency staff knew a residents transfer status or if the resident was a fall risk. CNA 9 stated Agency had a binder but she did not know what was in the binder. CNA 9 stated staffing was a hit and miss. CNA 9 stated she was unable to complete showers, rounds were usually over the two hour mark, vital signs were hard to get done, sometimes she was unable to get the meal trays out of the rooms, and garbages were not taken out till the end of shift. CNA 9 stated that she talked to the old DON and Administrator about staffing and they were very aware of the problem. CNA 9 stated she was told they were working on it. CNA 9 stated she talked to the CNA coordinator, who did CNA scheduling because she left her shift and there was only one CNA for the whole building and the CNA was on the rehabilitation side. CNA 9 stated that CNA was agency and the CNA was very upset and said she was leaving also. CNA 9 stated there were complaints from residents regarding staffing and she was not sure what to do with that information. CNA 9 stated there was a nurse and four CNA's that were very upset and filed complaints with the state survey agency regarding staffing because management was not listening to them. 9. On 9/27/22 at 12:01 PM, an interview was conducted with RN 5. RN 5 stated she had worked at the facility for two years and was currently an agency nurse. RN 5 stated she thought there were three to four CNAs for the 300 and 400 hallways and one and half nurses during the day. RN 5 stated staffing was the reason she left and started working for an agency. RN 5 stated with the staffing at four CNA's on the 300 and 400 hallways she felt like they were able to give proper care, rather than just give care. RN 5 stated the 300 and 400 hallways needed four CNAs and a shower CNA to be ideal. RN 5 stated that when there were only two CNA's for the 300 and 400 hallway, she was unable to obtain vital signs or complete charting because the residents came first. 10. On 9/28/22 at 9:29 AM, an interview was conducted with RN 3. RN 3 stated that Staffing is a mess. RN 3 stated staffing had gotten better in the last few weeks. RN 3 stated the previous Administrator felt that one nurse and one CNA was enough for the full facility at night. RN 3 stated not enough staff caused a lot of issues, like resident's were not getting changed and getting butt rashes. RN 3 stated one nurse was not enough. RN 3 stated she did not have enough time to complete a full head to toe assessment on everyone, pass medications, and it was impossible to do everything each day. RN 3 stated on the 300 and 400 hallways the work load was more manageable but she still did not have enough time to adequately care for residents herself. On 9/29/22 at 11:00 AM, a follow up interview was conducted with RN 3. RN 3 stated things get very busy and she forgets to get everything done. RN 3 stated a nurse was leaving at noon and going to the other side. RN 3 stated she still had a ton of things to note. RN 3 stated there was not enough staff, and there needed to be one nurse for the 300 hallway and one nurse for the 400 hallway. RN 3 stated it's just crazy. RN 3 stated It's so stressful for me, RN 3 stated I just have so many things to note and follow up on but with almost 40 residents it's impossible to get everything done especially charting. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465129	A. Building B. Wing	10/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Parkway Health Center	55 South Professional Way Payson, UT 84651

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	465129	A. Building B. Wing	10/03/2022

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F 0725 Level of Harm - Actual harm Residents Affected - Few	On 9/26/22 at 12:22 PM, an interview was conducted with resident 23. Resident 23 stated that the weekend staff were kind of stretched, with only one licensed nurse and two CNA's on shift. Resident 23 stated she had to wait two hours for pain medicine to be administered, and this occurred her last night. Resident 23 stated that there was just one nurse on shift. Resident 23 stated that the medication can only be administered every six hours and then she had to wait an additional two hours after that before it was administered. Resident 23 stated that her pain was located in the femur and feet. Resident 23 stated that no one could help me because they were so busy. Resident 23 stated that the pain was a 10/10, on a scale of 1 to 10. Resident 23 stated that it made her mad as hell, and no one provided help. Resident 23 stated that they have had to wait for assistance usually between 6:00 PM to 10:00 PM, and the last couple of nights it had been really bad. 19. On 09/27/22 at 10:03 AM, an interview was conducted with Restorative Nurse Assistant (RNA) 1. RNA 1 stated that she was the only RNA for the facility, and she worked Monday through Friday. RNA 1 stated that she was trying to work on getting the RNA program going. RNA 1 stated that she started providing RNA services at the beginning of September 2022, and prior to September they were working on rebuilding the program. RNA 1 stated that she began working at the facility in January 2022, and that there was not a RNA program until she began doing it. RNA 1 stated that in April or May 2022 there was one other RNA who was providing RNA services Monday through Friday. 20. On 10/3/22 at 9:06 AM, an interview was conducted with RN 6. RN 6 stated that she worked for an agency, and that this was the third shift at the facility. RN 6 clarified that this was her third shift working as an agency nurse period. RN 6 stated that she was an emergency room (ER) nurse and working agency in Long Term Care settings was new to her. RN 6 stated that when a resident had a change in condition she was not sure what the process would be, but she called the DON. RN 6 provided an example of a resident who had sustained a fall the prior day. RN 6 stated that the resident was on an anticoagulant and believed that they should be evaluated in the ER after the fall. RN 6 stated that they attempted to contact the resident's provider. RN 6 stated that they had left a voicemail for the NP, but never heard a response back. RN 6 stated that she then notified the DON and they agreed to send the resident to the hospital. RN 6 stated that the DON instructed her to document the incident in a fall report. RN 6 stated stated she would have liked to do a progress note, but that she did not know how to use the electronic medical records system. RN 6 stated that she was not provided any instructions on how to use the medical records system and she had not used it prior to coming to this facility. RN 6 stated that she had received no orientation to the facility. RN 6 stated she was provided the DON's phone number and login credentials for the electronic medical records. RN 6 stated that the previous nurse gave her the medical records website to login and access the Medication Administration Record (MAR). RN 6 stated that she was able to navigate the system, but it took longer to educate herself on the system. RN 6 stated that she would have liked to have had some sort of orientation. RN 6 stated that she did not know how to navigate beyond the MAR. RN 6 stated that she did not know how to access the resident's care plan until today when another nurse showed her. RN 6 stated she would have liked to know the patients diagnoses and plan of care. (continued on next page)

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	465129	A. Building B. Wing	10/03/2022

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	465129	A. Building B. Wing	10/03/2022

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F 0725 Level of Harm - Actual harm Residents Affected - Few	On 9/28/22 at 12:48 PM, an interview was conducted with the Administrator. The Administrator stated that he guessed an unassigned was picked up by a staff member but not written on the schedule. The Administrator stated that other staff members that filled in for CNA shifts were the RA, Housekeepers who were Nursing Assistants and other staff. The Administrator stated that he signed a contract with another agency service on 9/15/22, when he started as the Administrator. The Administrator stated there were not enough staff so that was his first thing as an Administrator to get better staffing.

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	465129	A. Building B. Wing	10/03/2022

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F 0745 Level of Harm - Actual harm Residents Affected - Few	Provide medically-related social services to help each resident achieve the highest possible quality of life. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38031 Based on interview and record review it was determined, for 1 out of 34 sampled residents, that the facility did not provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being. Specifically, a resident had expressed desires to die by refusal of treatment for diabetes and was not evaluated and seen by social services. Resident identifier: 20. Findings included: Resident 20 was admitted to the facility on [DATE] with diagnoses which included tinea cruris, repeated falls, hyperkalemia, hypertension, type 2 diabetes mellitus, neuropathy, multiple rib fractures, and osteomyelitis. On [DATE], resident 20's medical record was reviewed. Review of resident 20's physician's orders revealed: a. Lantus Insulin (insulin glargine) insulin pen; 100 unit/milliliter (mL); inject 35 units subcutaneously two times a day. The order was initiated on [DATE]. b. Blood Glucose Checks two times a day. The order was initiated on [DATE]. c. A regular diet was ordered on [DATE]. d. Duloxetine capsule, delayed release 60 milligram by mouth one time a day for nerve pain. The order was initiated on [DATE]. On [DATE], a Pre-Admission Screening Applicant/Resident Review (PASRR) documented that resident 20 had medical diagnoses only and no psychiatric or intellectual disability diagnoses. On [DATE], a Provider Order for Life-Sustaining Treatment (POLST) order documented that resident 20's advance directives were do not attempt or continue any resuscitation. The medical interventions documented were Limited Additional Interventions: Treating medical conditions while avoiding burdensome measures. Medical care may include treatment of airway obstruction, bag/valve/mask ventilation, monitoring of cardiac rhythm, Intravenous (IV) fluids, IV antibiotics and other medications as indicated. On [DATE], the resident signed a Risk verses (vs.) Benefit form for a diabetic diet. The form listed the benefits of following the diet were controlled blood sugar, controlled weight, glycated hemoglobin (A1C) lab values within normal range, and increased energy. The risks of not following the diet were possible increased blood sugar and A1C, possible weight gain, complications such as retinopathy, neuropathy, and nephropathy, stroke, and lethargy. On [DATE], the resident signed a Risk vs. Benefit for a treatment refusal of a diabetic diet. (continued on next page)

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	465129	A. Building B. Wing	10/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0745 Level of Harm - Actual harm Residents Affected - Few	It should be noted that no documentation could be found for a risk vs. benefit for the refusal of treatment of hypoglycemia. Review of resident 20's progress notes revealed the following: a. On [DATE] at 10:50 PM, the nurse documented, At 2130 [9:30 PM] [resident 20] BG [blood glucose] level was high, we check it twice, I gave him 12 units of insulin and asked him if I could check it in 15 minutes. Twenty minutes later, a CNA [Certified Nurse Assistant] went to check him and he was rude to her. I was going to check on him, heard him and offered to check his BG. I pocked (sic) him but he did not bleed enough and he refused to get him blood glucose check. I educated him on the risks, he stated that he didn't care. b. On [DATE] at 10:35 AM, the nurse documented, . he yelled at me and refused to let me take his blood sugar. I explained the importance of taking insulin and he still declined and yelled at me to get out of his room. c. On [DATE] at 3:17 AM, the nurse documented, Pt [patient] refused insulin. Educated about the importance of diabetic management and still refused insulin. d. On [DATE] at 4:16 AM, the nurse documented, Pt has been refusing all medication and care regimens throughout the shift. Educated about the importance of regulating blood sugar levels with the use of insulin and antibiotic therapy. Pt has been presenting anger towards the staff. e. On [DATE] at 12:54 AM, the nurse documented, Patient stated that he is not taking any antibiotic or accepting any txs [treatments] today. He stated that the doctor were treating him as a [NAME] pig> he has refused to get his blood glucose checked, refused to take any insulin but he stated that he would the (sic) some long acting insulin in the morning. f. On [DATE] at 10:18 AM, the nurse documented that the wound physician educated resident 20 about his diabetes and the importance of keeping his blood sugars down, taking his medication, and eating a well balanced diet. g. On [DATE] at 2:36 PM, the nurse documented, Pt is noted refusing all medications besides IV abx [antibiotics]. Pt refused for BGL [blood glucose level] to be checked and is also refusing insulin. Notified MD [Medical Doctor]. h. On [DATE] at 5:01 PM, the nurse documented, Pts BGLs have been low these last couple of mornings. Yesterday it was 60 and today it was 52. Notified MD. Pt refused lantus this morning and refuses to lower the dose, says he wants to give it a couple of days. Notified MD. i. On [DATE] at 9:26 PM, the nurse documented, PT HAD LOW BG THIS AM. IT WAS REPORTED TO ME THAT PT HAD RECENT INCREASE OF LANTUS DOSE GIVEN BID [two times a day]. PT REFUSED TO LET ME CHECK BG BEFORE GIVIN (sic) HS DOSE OF LANTUS. IT WAS REPORTED TO ME THAT HE DID NOT EACH MUCH OF HIS DINNER. I ATTEMPTED TO EDUCATE THE PATIENT ABOUT WHY I WOULD LIKE TO CHECK HIS BLOOD SUGAR BEFORE GIVING THE HS [bedtime] DOSE. PT REFUSED THE GLUCOSE CHECK AND REFUSED HIS OTHER HS MEDICATIONS INCLUDING A PAIN MEDICATION WHICH HE REQUESTED STATING 'IF HE HAS TO BEG FOR HIS LANTUS HE WANTS NOTHING' I AGAIN ATTEMPTED TO EDUCATE HIM ON THE REASON FOR CHECKING HIS BLOOD SUGAR BEFORE GIVING A HIGH RISK MEDICATION. I ALSO ATTEMPTED TO HAVE HIM SIGN A RISK V BENEFIT DOCUMENT. HE ALSO REFUSED TO SIGN.

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	465129	A. Building B. Wing	10/03/2022

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F 0745 Level of Harm - Actual harm Residents Affected - Few	p. On [DATE] at 9:55 AM, the NP documented, He had another episode of hypoglycemia, which required with a gun. He continues to state that he wants to be a DNR [Do Note Resuscitate], is resistant to treatments and cares. He states he does not decline treatment, facility staff report he will refuse his wound care. Diet is very irregular, he states the food is not good so he will not eat often. It should be noted that no documentation was found of the episode of hypoglycemia that was reported by the NP. q. On [DATE] at 9:10 AM, the nurse documented, i worked Sunday 09042022 and pt stated next nurse who gave him glucagon was being sued by him and that he is purposely not eating causing his blood sugar to go low so he can die, at this time myslef (sic) and [nurse name omitted] noticed accucheck 48 and pt refusing glucagon and gel and he shakes his head no and mumbles no to medicine, he is now at 38 with same response, pt is a dnr and able to make his own decisions, adament (sic) about not getting glucagon, will cont [continue] to monitor. r. On [DATE] at 9:15 AM, the nurse documented BS was 46 at 0730 [7:30 AM] . is now 38 at 0900 [9:00 AM]. Will barely respond to me/sternal rub but mumbles when I ask if he wants glucose gel or not. Is breathing heavy, [nurse name omitted] LPN [Licensed Practical Nurse] notified me that he said to not give glucose again this past Sunday after the nurse administered. Will not take meds [medications], drink anything, or swallow applesauce. Will continue to monitor. s. On [DATE] at 9:31 AM, the nurse documented that the NP was notified of resident 20's hypoglycemia and refusal of glucagon. t. On [DATE] at 12:40 PM, the nurse documented, called [name of hospital emergency room] and spoke with charge nurse [name omitted] who stated if pt is making his own decisions and refusing glucagon, he has his right to refuse, at this time pt is breathing and laying down in bed with employees checking on him multiple times per hour. u. On [DATE] at 1:09 PM, the nurse documented, pt has been educated multiple times on nutrition and hypogylcemia (sic) and ase [adverse side effects] over his stay here including this morning when he refused glucagon from other nurse and on Sunday [DATE] by myself,care team also notified of pts status today. v. On [DATE] at 1:56 PM, the nurse documented, pt talking and awake with blood sugar at 52 and states he wants to smoke and still refusing glucagon but is also eating a brownie for lunch. w. On [DATE] at 2:30 PM, the nurse documented, pt given glass of pepsi and also wound arnp [Advanced Registered Nurse Practitioner] here and pt gave her permission for glucose injection which she gave in luq [left upper quadrant] without ase, glucose cont at 58 and still eating brownie and able to make needs known. x. On [DATE] at 2:47 PM, the nurse documented, pts arnp and nurse here to see his foot wound and have discussed with him his options again and they report he wants to go by ambulance to [name of hospital omitted], medics called and transporting him and current blood sugar is now 70, have not heard the pt say he has changed his mind and asked him but he doesn't answer that question and arnp states he gave her permission and is cooperating with ems [emergency medical services], face sheet, dnr polst and med list given to ems (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465129	A. Building B. Wing	10/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Parkway Health Center	55 South Professional Way Payson, UT 84651

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F 0745 Level of Harm - Actual harm Residents Affected - Few	y. On [DATE] at 5:13 PM, the nurse documented, after ems responded to arnp wound dr [doctor] calling them, pt refused transport and refused any further treatment for hypoglycemia and states he will sign risks and benefits for not being treated in the future for hypoglycemia and also signed new post form for NO treatment including diabetes tx [treatment] with interim DON, blood sugar wnl [within normal limits] rest of this shift and will pass on report. z. On [DATE] at 3:41 PM, the nurse documented, Called and spoke with [name omitted] (resident's podiatrist) to inquire about Vanco and give him status update on resident request to decline glucagon and non-compliance with treatments and assistance with cares in general. Discussion also completed with resident regarding wishes as it pertains to POLST status. Resident continues to request to be changed from limited DNR to DNR comfort measures, but does not wish to sign updated POLST to reflect this and won't state rationale for not wanting to sign it. Resident continues to be alert and oriented and able to make his decisions and was educated upon the risks of not signing updated POLST that show his current wishes and that he would have to be treated with his previous limited DNR if we don't get a signed update version. He stated, 'No, I won't take glucagon ever again.' Resident has been approached regarding possible benefits to hospice. Resident refuses hospice assessment at this time. Social work is aware of resident status. Resident denies any thoughts or plans of self-harm Nurse practitioner notified of all of the above and resident made aware of new orders. aa. On [DATE] at 10:21 PM, the nurse documented, Resident requested to have duloxetine discontinued after refusing it. States that he doesn't need to take those psycho meds. Discussed with NP, order given to discontinue medication. Resident aware. bb. On [DATE] at 941 AM, the NP documented, He is adamant on his insulin dose, and refuses any changes. He did sign a risk versus benefit regarding this. He is quite particular about his diet, and will often not eat if he does not like the food, which will then cause him to be hypoglycemic. He also frequently refuses his blood sugar checks and other cares from staff. Antibiotics have been completed, he is anxious to be able to discharge, unable to do so until wounds heal. cc. On [DATE] at 835 PM, the nurse documented, Nurse entered resident's room to administer morning medications. Nurse found resident with labored and increased respirations, extremely diaphoretic and using accessory muscles to breathe. Also noted a congested sound in resident's chest. Nurse assessed blood glucose level which was 42. Also assessed oxygen saturations which were 72% on room air. Nurse attempted to wake resident, who was only responsive with grunts and slight groaning. Nurse and CNAs pulled resident up in his bed and elevated the HOB [head of bed] to 45 degrees. Per conversations with previous nurses and management team, resident has adamantly stated that he is DNR and absolutely does not want glucagon IM [intramuscular] administered. This nurse was informed that he would accept oral glucose gel. Nurse pulled oral gel from pixis [sic] and administered the tube to resident's buccal pouch a small amount at a time. At one point, resident swallowed the gel, and more was administered. Entire contents of tube were given. Oxygen sats were again assessed and found to be fluctuating between 88 and 93% on room air. Approx. 15 minutes after oral glucose gel was administered, resident is still unresponsive. dd. On [DATE] at 8:48 AM, 15 minutes after glucose gel administration, blood glucose reassessed and remains at 42. Resident continues to be unresponsive but is loudly moaning with breathing. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465129	A. Building B. Wing	10/03/2022

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F 0745 Level of Harm - Actual harm Residents Affected - Few	ee. On [DATE] at 8:53 AM, the nurse documented resident 20's vital signs as: blood pressure ,d+[DATE], respiratory rate 32, oxygen saturation 91% on room air, heart rate 111, and temperature was 97.4 degrees Fahrenheit. ff. On [DATE] at 9:09 AM, the nurse documented, Blood glucose is now 36 and resident continues with moaning while breathing. Respirations have come down to 12 per minute with periods of apnea. Oxygen continues to fluctuate from high ,d+[DATE]% on room air. gg. On [DATE] at 9:45 AM, the nurse documented, MD and management have been notified of resident's status via tiger text. hh. On [DATE] at 10:05 AM, the nurse documented, Blood glucose is now 38. Resident continues to be unresponsive when nurse speaks to him, also unresponsive with sternal rub. Moaning with breathing remains. No next of kin contacts listed to call and update. ii. On [DATE] at 10:13 AM, the nurse documented, Nurse heard louder moaning coming from resident's room. Nurse entered to find resident with is (sic) eyes wide open and looking around his room. Nurse said , 'Hi, [resident 20's name omitted]!' Nurse asked him if he was comfortable. [Resident 20's name omitted] looked at nurse and shook his head no. Nurse asked if he wanted her to reposition him. He looked at her and he shook his head no again. Nurse told him his blood sugar was low and asked if he would like glucagon. [Resident 20's name omitted] looked at nurse, furrowed his eyebrows and shook his head very hard no again. Nurse told him that his oxygen had been getting low and asked if he would like oxygen. He again looked at nurse with furrowed eyebrows and shook his head with a hard no. Nurse told him that she would respect his wishes and would not do anything he didn't want done. He then closed his eyes and started moaning again. Nurse updated management. jj. On [DATE] at 10:50 AM, the nurse documented, Nurse entered resident's room to reassess. Noted no breathing. Nurse auscultated for heart sounds-none present. Management notified of resident's passing. Review of resident 20's Care Plans revealed no focus areas that addressed diabetes, insulin, nutrition, or refusal of cares. (continued on next page)

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	465129	A. Building B. Wing	10/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0745 Level of Harm - Actual harm Residents Affected - Few	On [DATE] at 10:03 AM, an interview was conducted with LPN 1. LPN 1 stated that she was an agency nurse, had worked at the facility prior, and was familiar with the residents. LPN 1 stated that if she had a resident with a low BS, she would give them juice or sugar if they were able to have oral intake. LPN 1 stated if the resident was not able to take anything by mouth then they should have standing orders for glucagon or glucagel. LPN 1 stated that all sliding scale orders for insulin also stated to contact the physician if the BS was less than 80. LPN 1 stated that there was usually an order for glucagon as needed or the physician would order it when they were contacted. LPN 1 stated that if a resident refused the glucagon then she would contact the physician to see what should be done next. LPN 1 stated that it would also depend on if the resident was coherent and able to refuse the medication. LPN 1 stated that if they were unable to get a hold of the provider they would transfer the resident to the hospital for further evaluation and treatment. LPN 1 then stated that she would still need an order to transfer the resident, so she would wait for an order from the provider. In my experience diabetic patients have an order for glucagon. LPN 1 stated that she would verify the glucagon order in the Medication Administration Record. LPN 1 stated that if it was passed off in report that the resident was refusing treatment and was not able to provide that information for themselves then she would still contact the provider. LPN 1 stated that she would not direct her care and treatment based off of nurse's notes if the resident could not speak for themselves. LPN 1 stated that she would refer to a POLST form which would indicate the resident's preferred resuscitation status and preference for medical treatment. LPN 1 stated that if the resident was unresponsive and there were questions about the resident refusing treatment in the past it would be helpful to look at that document. LPN 1 stated that she was familiar with resident 20. LPN 1 stated that resident 20's cognitive status was alert and oriented times 3, person, place, and time. LPN 1 stated that resident 20 was able to make his own decisions. LPN 1 stated she recalled caring for him and having him refuse BS checks in the morning. LPN 1 stated she was informed that resident 20's BS dipped a lot. LPN 1 stated that she was careful with resident 20's insulin administration and would not administer if he did not allow a BS check. LPN 1 stated that resident 20 thought the BS should be checked before breakfast but he would not wake until lunch. LPN 1 stated that she would obtain the BS check before lunch to accommodate the resident. LPN 1 stated that resident 20 did not eat well, and he did not like what was being served. That was a compliant of his. LPN 1 stated she knew he liked oatmeal so she would make him oatmeal so he had something to eat. LPN 1 stated that the insulin was scheduled for morning administration, but they would not administer the medication until they had a BS check. LPN 1 stated that a lot of time resident 20 was upset with her for not administering the medication. LPN 1 stated that resident 20 refused a lot of care and medication, and was opinionated on what he should and should not have. LPN 1 stated that resident 20 always refused his Duloxetine for depression, saying I'm not taking that crap. LPN 1 stated that the one time resident 20 was hypoglycemic she could not recall if she notified the physician. LPN 1 stated she recalled being told in report that resident 20's BS was low the previous day, that he was administered glucagon on a previous shift, and that he refused going to the hospital for hypoglycemia. LPN 1 stated that she was never informed that resident 20 had refused treatment with glucagon. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465129	A. Building B. Wing	10/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Parkway Health Center	55 South Professional Way Payson, UT 84651

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F 0745 Level of Harm - Actual harm Residents Affected - Few	On [DATE] at 12:31 PM, an interview was conducted with Registered Nurse (RN) 5. RN 5 stated that the resident would refuse wound care, most of his medication and his psych pills. RN 5 stated that resident 20 would take his blood pressure medication and the long acting insulin. RN 5 stated that resident 20's BS typically ran high. RN 5 stated she would educate resident 20 on his BS, and he would say I know, but didn't care. RN 5 stated that if resident 20's BS was 500 she would ask if she could administer the short acting insulin. RN 5 stated resident 20 wanted the long acting insulin and refused the short acting insulin. RN 5 stated that when resident 20's BS was low it was not that bad, and she would give the resident milk and a peanut butter and jelly sandwich. RN 5 stated that the low BS that she recalled for resident 20 were 60 or 70, and maybe 55 one day. RN 5 stated that resident 20 was alert and oriented times 4 and could communicate his needs. RN 5 stated that resident 20 was able to make decisions about his care. RN 5 stated that after she provided the milk and peanut butter sandwich she would recheck the BS in an hour. RN 5 stated sometimes resident 20 would tell her to come back in 30 minutes if he was sleeping. He wanted to run his own show. RN 5 stated the process for a resident who was hypoglycemic was to first notify the NP, treat the resident with milk and a peanut butter and jelly sandwich, applesauce or juice, then monitor the BS. RN 5 stated that if the BS did not increase she would give more of the listed foods. RN 5 stated that if the resident was unresponsive and the BS was low she would administer glucagon intramuscular or administer the glucose gel. RN 5 stated that she never had to administer glucagon or glucose gel to resident 20, but thinks that it was administered by another nurse. RN 5 stated that resident 20 never refused cares with her. RN 5 stated, sometimes if he didn't like a person he wouldn't do what they asked. RN 5 stated that resident 20 was not on hospice services, but he did have a DNR order to not perform compressions. RN 5 stated that she would continue to provide resident 20 with care and treatments until he no longer had a pulse. RN 5 stated that if resident 20 no longer wanted treatment for diabetes then it should have been documented on the POLST form in the notes. RN 5 stated that resident 20 had the short acting insulin discontinued, but that he had standing orders for glucagon. RN 5 stated that glucagon was automatically in the orders on the previous medical records system. RN 5 stated that if she found resident 20 unresponsive with a low BS she would have administered glucagon. RN 5 stated that there should have been a care plan that addressed resident 20's diabetes. RN 5 stated that for any refusals of care she was not sure if that was documented in a care plan. RN 5 stated that for refusals of care they usually completed a risk vs. benefits. RN 5 stated she was not sure if this was done for resident 20, but that it was discussed. RN 5 stated that she was aware that the NP gave orders in a tiger text communication that a Risk vs. Benefit needed to be completed for the discontinuation of the short acting insulin. RN 5 stated that resident 20's mood depended on the day and who you were. RN 5 stated that resident 20 was good with her, and if she asked him to please do something he would. RN 5 stated that if resident 20 did not like a staff member he would tell them no to everything. RN 5 stated that resident 20 had signs and symptoms of depression and would isolate himself in his room and have everything dark. RN 5 stated that resident 20 refused his medication for depression. RN 5 stated she was not aware if resident 20 saw anyone with behavior health or a Social Service Worker (SSW) about his depression. RN 5 stated that she believed that the resident advocate (RA) took over for the SSW. RN 5 stated that they had a SSW from behavioral health that came to the facility 1 to 2 times a month, but she was not sure if resident 20 was seen by them. On [DATE] at 2:02 PM, a follow-up interview was conducted with LPN 1. LPN 1 stated that resident 20 was on Duloxetine for depression. LPN 1 stated that resident 20's signs and symptoms of depression were that he slept all the time. He wasn't happy about being here. LPN 1 stated she was not sure if resident 20 saw the SSW at the facility or any contracted behavioral health services. LPN 1 stated that the RA was the SSW. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465129	A. Building B. Wing	10/03/2022

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F 0745 Level of Harm - Actual harm Residents Affected - Few	On [DATE] at 9:58 AM, an interview was conducted with RN 3. RN 3 stated that she recalled resident 20, and he was a DNR with limited interventions. RN 3 stated that resident 20 has since passed but recalled that the resident did not want the medication glucagon. RN 3 stated that for residents who were DNR, she would verify on the POLST for if it was limited interventions or comfort measures. RN 3 stated that she administered glucagon to resident 20 in the past and recalled looking at the POLST and it said DNR with limited interventions. RN 3 stated that she recalled working with an agency nurse that day who was resident 20's nurse. RN 3 stated that the agency nurse told her that the POLST documented DNR, but she was confused on if she should resuscitate resident 20 because it said limited interventions. RN 3 stated that she educated the other nurse that limited interventions meant that they should still provide treatment. RN 3 stated that if the BS was low they could give glucagon or any other interventions to keep resident 20 stable. RN 3 stated that after this incident she believed that resident 20 signed a new POLST form for DNR with comfort measures only. RN 3 stated that resident 20 had an episode of hypoglycemia and they honored his wishes and did not administer glucagon and he passed. RN 3 stated that on the day of resident 20's passing she called the DON. RN 3 stated that she did not see the updated POLST form with comfort measures only. RN 3 stated that on the day that resident 20 died , they administered the glucagon gel, but not the glucagon IM. RN 3 stated that she did not administer the gel, but that she pulled it from the Pyxis and gave it to the other nurse. RN 3 stated that the other nurse was an agency nurse and she wanted to give the glucagon gel. RN 3 stated that she was the only nurse who had access to the Pyxis and she pulled the gel. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465129	A. Building B. Wing	10/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Parkway Health Center	55 South Professional Way Payson, UT 84651

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F 0745 Level of Harm - Actual harm Residents Affected - Few	On [DATE] at 10:18 AM, and interview was conducted with the RA and the Corporate Social Service Worker (CSSW). The RA stated that her duties included the following: scheduling resident appointments; conducting a Brief Interview for Mental Status (BIMS) exam; conducting Patient Health Questionnaire-9 (PHQ-9) screening to assess for depression; obtaining a social history; conducting Interdisciplinary Team conferences; discharge planning; arranging home health services; assisting with New Choice Waiver paperwork; and referrals to mental health if needed. The RA stated that the PHQ-9 were based off the Minimum Data Set (MDS) assessment and she completed them for all the MDS assessments. The RA stated that she had been doing them for the past 8 weeks. The RA stated that she was transitioning from the business office to the RA. The RA stated that they had a contracted mental health service that the facility referred residents to. The CSSW stated that the facility had a Licensed Clinical Social Worker available, but that she was at the facility more often. The CSSW stated that the RA would initially talk to the residents and would ask if they wanted to see someone from mental health services. The CSSW also stated that if the RA did not know how to handle a situation she would refer the resident to the CSSW. The CSSW stated at that point she would have a discussion with the resident and make any necessary referrals. The RA stated that she had talked to resident 20. The RA stated that resident 20 had refused a lot of his cares. The RA stated that resident 20 had wanted to go out on a New Choice waiver, the paperwork had been submitted, and was being reviewed at the time of his passing. The RA stated that she obtained a PHQ-9 score on resident 20. The RA stated that the score would give indicators for the resident's mood. The CSSW stated that the most recent assessment on [DATE], had a PHQ-9 score of 1 out of 30, which indicated minimal depression. The RA stated that she did not have any indicators of depression for resident 20 and was never notified of depressive symptoms from the nurses. The CSSW stated that resident 20's Duloxetine was prescribed for nerve pain. The CSSW stated that if resident 20 was having any signs and symptoms of depression or suicidal ideation (SI) she would expect the nurses to report that to her. The RA stated that if this information was communicated to her she would have had a conversation with resident 20 she would have consulted with the CSSW. The CSSW stated that if resident 20 had expressed wishes to harm himself they would have sent him to the hospital for evaluation. The CSSW stated that resident 20 had refused to go to the hospital for treatment in the past, but there was no indication that he was suicidal. The RA stated that as far as she was aware resident 20 wanted to live in assisted living or independent living, had toured a couple of facilities, and was looking forward to that. The CSSW stated that according to resident 20's PHQ-9 score and expressed desire to discharge they were not aware of any indications of SI or wanting to die. The CSSW stated that had they been made aware of these statements they would have had a discussion about options for resident 20. The CSSW and the RA stated that resident 20 did not have any referrals made to mental health services. On [DATE] at 11:30 AM, an interview was conducted with the DON. The DON stated that resident 20 was a very self directed man, meaning he refused cares, refused dressing changes, decided what medications to take, and when to take them. The DON stated that resident 20 had refused antibiotics, insulin, Fluconazole, Gabap [TRUNCATED]

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	465129	A. Building B. Wing	10/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Parkway Health Center	55 South Professional Way Payson, UT 84651

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33215 Based on interview and record review, it was determined, that the facility did not provide routine and emergency drugs and biologicals to its residents. Specifically, for 7 out of 34 sampled residents, resident medications were not administered as ordered by the physician due to the medications not being available by the pharmacy. Resident identifiers: 22, 23, 29, 30, 49, 53, and 160. Findings included: 1. Resident 22 was admitted to the facility on [DATE] with diagnoses which included, but not limited to, nontraumatic intracerebral hemorrhage, hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, type 2 diabetes mellitus, essential hypertension, muscle weakness, and chronic pain syndrome. On 9/26/22 at 10:32 AM, an interview was conducted with resident 22. Resident 22 stated that staff were not bringing her medications timely. Resident 22 stated that she would ask for her anxiety medication and it would take along time for the staff to bring the medication. Resident 22 stated the staff would tell her there was only one nurse. Resident 22 stated that some staff were better than others. Resident 22 stated that she did not always get her diabetic medications before meals. Resident 22's medical record was reviewed on 9/27/22. The September 2022 Medication Administration Record (MAR) was reviewed. The following entries were documented: a. On 9/3/22 at 6:00 PM - 10:00 PM, heparin solution; 5,000 unit/milliliter twice a day was not administered due to Drug/Item Unavailable. b. On 9/17/22 at 6:00 AM - 10:00 AM, duloxetine capsule delayed release 30 milligrams (mg) was not administered due to Other Comment: medication not available, Pharmacy notified. c. On 9/18/22 at 6:00 AM - 10:00 AM, Acidophilus 1 capsule was not administered due to Drug/Item Unavailable. d. On 9/19/22 at 6:00 AM - 10:00 AM, duloxetine capsule delayed release 30 mg was not administered due to Drug/Item Unavailable. e. On 9/19/22 at 6:00 AM - 10:00 AM, fluoxetine capsule 40 mg was not administered due to Drug/Item Unavailable. f. On 9/20/22 at 6:00 AM - 10:00 AM, duloxetine capsule delayed release 30 mg was not administered due to Drug/Item Unavailable. g. On 9/20/22 at 6:00 AM - 10:00 AM, fluoxetine capsule 40 mg was not administered due to Drug/Item Unavailable. (continued on next page)

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	465129	A. Building B. Wing	10/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	h. On 9/21/22 at 6:00 AM - 10:00 AM, fluoxetine capsule 40 mg was not administered due to Drug/Item Unavailable. 2. Resident 49 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included, but not limited to, hemorrhage of anus and rectum, dementia, history of falling, type 2 diabetes mellitus with hyperglycemia, displaced fracture of second cervical vertebra, major depressive disorder, systolic congestive heart failure, secondary hypertension, and edema. Resident 49's medical record was reviewed on 9/27/22. The September 2022 MAR was reviewed. The following entries were documented: a. On 9/5/22 at 6:00 AM - 10:00 AM, Anusol-hydrocortisone acetate suppository 25 mg twice a day was not administered due to Drug/Item Unavailable Comment: MD [Medical Director] and pharm [pharmacy] notified. b. On 9/6/22 at 6:00 PM - 10:00 PM, Miconazorb powder 2% topical twice a day was not administered due to Drug/Item Unavailable Comment: MD and pharm notified. c. On 9/8/22 at 6:00 PM - 10:00 PM, Miconazorb powder 2% topical twice a day was not administered due to Drug/Item Unavailable Comment: MD and pharm notified. d. On 9/23/22 at 5:00 AM, levothyroxine 175 micrograms was not administered due to Drug/Item Unavailable. e. On 9/23/22 at 6:00 AM - 10:00 AM, potassium chloride 10 milliequivalent was not administered due to Drug/Item Unavailable. f. On 9/24/22 at 6:00 AM - 10:00 AM, metoprolol tartrate 25 mg twice a day was not administered due to Drug/Item Unavailable. g. On 9/26/22 at 6:00 AM - 10:00 AM, metoprolol tartrate 25 mg twice a day was not administered due to Drug/Item Unavailable. h. On 9/27/22 at 6:00 AM - 10:00 AM, metoprolol tartrate 25 mg twice a day was not administered due to Drug/Item Unavailable. 30563 3. Resident 29 was admitted to the facility on [DATE] with diagnoses which included low back pain, injury to left lower leg, hypothyroidism, edema, chronic pain, and nausea. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465129	A. Building B. Wing	10/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 9/26/22 at 12:32 PM, an interview was conducted with resident 29. Resident 29 stated she was unable to stand her pain last night and was groaning. Resident 29 stated there was no nurse on her hallway from 12:00 AM until 6:00 AM. Resident 29 stated she needed Tramadol at 2:00 AM but the nurse told resident 29 it was not her problem because she would not be there and there was not a nurse to administer the medication. Resident 29 stated she had scoliosis that made a hole in her spine and she had no control over her left lower extremities. Resident 29 stated she needed her Tramadol regularly because her pain never quit. Resident 29 stated her Tramadol was not administered at 2:00 AM when she wanted it. Resident 29 stated that her pain was at a 10 and she was crying and sick to her stomach. Resident 29 stated the nurse administered three pills to her early that morning and she did not know what the medications were. Resident 29's medical record was on 9/28/22. An admission Minimum Data Set (MDS) assessment dated [DATE], revealed that resident 29 frequently experienced pain. The MDS revealed resident 29 had pain that made it hard for her to sleep at night and limited her day-to-day activities. The MDS revealed resident 29 had as needed pain medications and no scheduled pain medications. A care plan created on 9/19/22, with a problem start date of 8/1/22, revealed resident 29 was at risk for pain secondary to chronic pain. The goal was resident 29 would have no unaddressed pain, through next review. The approaches included educate resident on newly prescribed medications, monitor for side effects, medications as prescribed, monitor pain as prescribed, and other non-pharmacological approaches to pain management. A current physician's order dated 8/2/22, revealed Lidocaine adhesive patch, medicated; 5%; topical apply patch to back daily. The MAR for August 2022 revealed Lidocaine adhesive patch was not administered on the following dates: a. On 8/23/22, Drug/Item Unavailable: Could not find b. On 8/24/22, Drug/Item Unavailable c. On 8/25/22, Drug/Item Unavailable d. On 8/26/22, Drug/Item Unavailable: Notified DON [Director of Nursing] - DON is getting more e. On 8/27/22, Drug/Item Unavailable: Waiting for delivery f. On 8/28/22, Drug/Item Unavailable g. On 8/29/22, Drug/Item Unavailable A current physician's order dated 8/1/22. revealed Voltaren Arthritis Pain (Diclofenac sodium) gel; 1%; topical administered three times per day. The instructions were to apply to knees and ankles. The diagnosis associated with the gel was low back pain. (continued on next page)

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	465129	A. Building B. Wing	10/03/2022

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The MAR for August 2022 revealed Voltaren gel was not administered on the following dates: a. On 8/9/22, No nurse b. On 8/30/22, Drug/Item unavailable c. On 8/31/22, Drug/Item unavailable The MAR for September 2022 MAR revealed the following: a. Acetaminophen 650 mg three times per day were not administered on 9/6/22, 9/7/22, and 9/8/22 because the Drug/Item was unavailable and on order. b. Lidocaine patch adhesive patch 5% topical once per day was not administered on 9/1/22, 9/2/22, 9/26/22, 9/27/22 because the Drug/Item was unavailable and needed to order more. On 10/3/22 at 11:57 AM, an interview was conducted with the Assistant Director of Nursing (ADON). The ADON stated if the medication was not available then it was because the pharmacy did not have a supply. The ADON stated medications like Tramadol were in the Pyxus system and he was not sure why the medication was not administered on 8/9/22, because there was always a nurse at the facility. 4. Resident 160 was admitted to the facility on [DATE] and discharged on [DATE] with diagnoses which included hypertension, diabetes mellitus, and atrial fibrillation. On 9/27/22 at 9:21 AM, an interview was conducted with resident 160's family member. Resident 160's family member stated resident 160's medications were all messed up when she was admitted . Resident 160's family member stated she talked to the previous DON about the medications but nothing was done. Resident 160's medical record was reviewed on 9/29/22. The February 2022 MAR revealed resident 160 was not administered Lipitor Tablet 40 mg at bedtime on 2/12/22, 2/14/22, 2/16/22, and 2/23/22. A progress note dated 2/12/22, revealed the medication was Unavailable, pharmacy contacted. On 2/14/22, 2/16/22, and 2/23/22, the medication was pending delivery. The February 2022 MAR further revealed resident 160 was not administered Hydralazine Hydrochloride 25 mg three times a day for hypertension on the following days: a. On 2/11/22 at 7:00 AM. b. On 2/12/22 at 7:00 AM. c. On 2/13/22 at 7:00 AM, 12:00 PM, and 7:00 PM. d. On 2/14/22 at 7:00 PM, e. On 2/15/22 at 7:00 AM and 12:00 PM. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The progress notes revealed on 2/11/22, the medication was Not available. On 2/12/22, Not available, pharmacy contacted. On 2/13/22, medication unavailable Pharmacy contacted. On 2/14/22, Pending delivery. On 2/15/22, Not available pharmacy notified. The February 2022 MAR further revealed resident 160 was not administered Metoprolol Succinate Extended Release (ER) 24 hour sprinkle 50 mg twice daily for hypertension on the following days: a. On 2/2/22 at 7:00 AM. b. On 2/3/22 at 7:00 PM. c. On 2/4/22 at 7:00 PM. d. On 2/14/22 at 7:00 PM. e. On 2/15/22 at 7:00 AM. f. On 2/16/22 at 7:00 AM. The progress notes revealed on 2/2/22, Medication not available. Notified pharmacy. On 2/3/22, Unable to locate medication. On 2/4/22, unable to locate ordered more. On 2/14/22, the medication was pending delivery. On 2/15/22, the medication was not available pharmacy notified. 2/16/22, Medication not available, notified pharmacy. The March 2022 MAR revealed resident 160 was not provided Metoprolol Succinate Capsule ER 24 hour sprinkle 50 mg on the following dates: a. On 3/6/22, at 7:00 PM dose. b. On 3/8/22, at 7:00 AM and 7:00 PM doses. c. On 3/9/22, at 7:00 AM and 7:00 PM dose. d. On 3/10/22, at 7:00 PM dose. e. On 3/11/22, at 7:00 AM dose. f. On 3/12/22, at 7:00 PM dose. g. On 3/13/22, at 7:00 AM dose. The progress notes revealed on 3/6/22, the drug was not on hand. On 3/8/22, the medication was pending delivery. On 3/9/22, Medication was not available. Notified pharmacy. Refill is too soon, notified DON and MD [Medical Director] and Pending Delivery. On 3/10/22, Unable to locate. Ordered more. On 3/11/22, Drug not available. On 3/12/22, medication no on hand pharm notified. On 3/13/22, Medication cannot be filled until the 16th. Notified DON of issue. Notified MD. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The March 2022 MAR further revealed resident 160 was not provided Loradine 10 mg by mouth one time a on 3/11/22. The progress notes revealed on 3/11/22, Drug not available. On 9/27/22 at 12:01 PM, an interview was conducted with Registered Nurse (RN) 5. RN 5 stated she had worked at the facility for two years and was currently an agency nurse. RN 5 stated if medication was not available nurses wrote it down on a sheet and then called the pharmacy. RN 5 stated the new system had a button to push to reorder medications. RN 5 stated that the night shift nurse went through and re-ordered the medications before the medication ran out. RN 5 stated if a resident was not administered Metoprolol, then she would want to make sure their blood pressures were not high. RN 5 stated sometimes Metoprolol was not given because the blood pressure was too low. RN 5 stated the physician provided parameters to hold the medication depending on the blood pressure. On 9/29/22 at 2:11 PM, an interview was conducted with the DON. The DON stated she did not have any additional information on resident 160's medications not being unavailable. 38031 5. Resident 30 was admitted to the facility on [DATE] with diagnoses which included cerebral infarction, abscess of perineum, muscular dystrophy, hypertension, type 2 diabetes mellitus, anxiety disorder, gastro-esophageal reflux disease, major depressive disorder, and cellulitis of the buttocks. On 9/28/22, resident 30's medical record was reviewed. Review of resident 30's physician's orders revealed the following: a. Escitalopram oxalate tablet 5 mg by mouth one time a day. The order was initiated on 8/2/22 and was discontinued on 9/26/22. b. Metoprolol tartrate tablet 100 mg by mouth one time a day. The order was initiated on 8/2/22. Review of resident 30's September 2022 MAR revealed the following: a. On 9/23/22 at 6:00 AM to 10:00 AM, the Escitalopram 5 mg was documented as Not Administered: Drug/Item Unavailable. b. On 9/7/22 and 9/9/22 at 6:00 AM to 10:00 AM, the Metoprolol 100 mg was documented as Not Administered: Drug/Item Unavailable. 6. Resident 53 was admitted to the facility on [DATE] with diagnoses which included surgical aftercare of the digestive system, edema, type 2 diabetes mellitus, morbid obesity, obstructive sleep apnea, anxiety disorder, major depressive disorder, insomnia, hypertension, benign prostatic hyperplasia, and chronic kidney disease. On 9/28/22 at 7:38 AM, an observation was made of RN 3 during the morning medication administration. RN 3 was dispensing medication for resident 53 and stated that the resident's Nystatin cream was not available and needed to be reordered. RN 3 stated she would document the medication as not administered. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 9/28/22 at 9:25 AM, RN 3 stated she was going to fax the Nystatin refill to the pharmacy and would expect to receive it around 2:00 PM. On 9/28/22 at 3:18 PM, RN 3 stated that she had just received the Nystatin cream from the pharmacy. On 9/29/22 at 11:03 AM, an interview was conducted with the DON. The DON stated that she was not sure if the Nystatin cream was stock item. The DON stated that staff should contact the pharmacy and have the medication reordered before it runs out. The staff should be aware of how much was remaining in the tube. On 10/3/22, resident 53's medical records were reviewed. Review of resident 53's physician's orders revealed the following: a. Daily Multivitamin-Minerals (multivitamin with minerals) one tablet by mouth one time a day. The order was initiated on 8/2/22. b. Macrobid capsule 100 mg by mouth at bedtime. The order was initiated on 8/1/22. c. Pantoprazole tablet 40 mg by mouth one time a day. The order was initiated on 8/2/22. Review of resident 53's September 2020 MAR revealed the following: a. On 9/14/22 and 9/15/22, the multivitamin was documented as Not Administered: Other Comment: ON ORDER. b. On 9/19/22, the Macrobid 100 mg medication was documented as Not Administered: Drug/Item Unavailable. c. On 9/26/22 and 9/27/22, the Pantoprazole 40 mg was documented as Not Administered: Drug/Item Unavailable. On 10/3/22 at 1:42 PM, an interview was conducted with the DON. The DON stated she would have to research why the medications were documented as not administered. The DON stated that if there was a reason to hold the medication, she would expect there to be a progress note documenting why. The DON stated that Multivitamins were a stock item and should be available. 7. Resident 23 was admitted to the facility on [DATE] with diagnoses which included fracture of right femur, congestive heart failure, gastro-esophageal reflux disease, deep vein thrombosis of lower extremity, insomnia, hypothyroidism, alcohol dependence, major depressive disorder, and post-traumatic stress disorder. On 9/26/22 at 12:22 PM, an interview was conducted with resident 23. Resident 23 stated that she had pain in her femur and feet. Resident 23 stated that the pain was a 10/10, on a scale of 1 to 10. Resident 23 stated that the pain in her feet was due to neuropathy and was so painful that she could hardly touch her feet to the ground. On 9/27/22, resident 23's medical record was reviewed. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of resident 23's physician's orders revealed the following: a. Buspirone tablet 5 mg by mouth three times a day. The order was initiated on 8/1/22 and discontinued on 9/26/22 b. Buspirone tablet 10 mg by mouth three times a day. The order was initiated on 9/26/22. c. Furosemide tablet 40 mg by mouth two times a day. The order was initiated on 8/2/22. d. Gabapentin tablet 600 mg by mouth three times a day. The order was initiated on 8/1/22. e. Amoxicillin tablet 500 mg by mouth three times a day. The order was initiated on 8/22/22 and discontinued on 8/29/22. Review of resident 23's August 2020 MAR revealed the following: a. On 8/29/22 at the 6:00 PM to 10:00 PM, administration time, the Amoxicillin 500 mg was documented as Not Administered: Drug/Item Unavailable. b. On 8/16/22 at the 6:00 PM to 10:00 PM, on 8/17/22 at the 6:00 AM to 10:00 AM, and at the 10:00 AM to 2:00 PM, administration time, the Buspirone 5 mg was documented as Not Administered: Drug/Item Unavailable c. On 8/16/22 at the 6:00 PM to 10:00 PM, on 8/17/22 at the 6:00 AM to 10:00 AM, and at the 10:00 AM to 2:00 PM, administration time, the Gabapentin 600 mg was documented as Not Administered: Drug/Item Unavailable Review of resident 23's September 2022 MAR revealed the following: a. On 9/14/22 at the 6:00 PM to 10:00 PM, administration time, the Buspirone 5 mg was not administered due to Drug/Item Unavailable b. On 9/21/22, 9/22/22, and 9/23/22 at the 6:00 AM to 10:00 AM and at the 10:00 AM to 2:00 PM, administration time, the Furosemide 40 mg was documented Not Administered: Drug/Item Unavailable. On 9/27/22 at 10:22 AM, an interview was conducted with RN 4. RN 4 stated that she was an agency nurse. RN 4 stated that this was her first full shift at the facility, and she had worked one other time for half a shift. RN 4 stated that she had noticed that all the staff today were agency. On 9/27/22 at 1:28 PM, a follow-up interview was conducted with RN 4. RN 4 stated that when she came on shift, she was handed a piece of paper to write down any medications that were out of stock. RN 4 stated that she was not informed of the process for ordering medication for a resident. RN 4 stated that she thought the facility had a Pyxis machine, that is how it is at all the facilities. RN 4 stated that she did not have an access code for the Pyxis dispensary, only the facility nurses were granted access. RN 4 stated that she had not been provided any instructions at this facility. (continued on next page)

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	465129	A. Building B. Wing	10/03/2022

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 9/27/22 at 10:03 AM and again at 1:57 PM, an interview was conducted with Licensed Practical Nurse (LPN) 1. LPN 1 stated that she was an agency nurse and had worked at the facility prior to becoming an agency staff. LPN 1 stated that if medications were running low, they would order them from the pharmacy. LPN 1 stated that when the blister pack had only the last row or column remaining, she would pull the reorder sticker and place on the refill sheet or check to make sure that it was not too early to refill the medication. LPN 1 stated that she had the ability to reorder some medications through the electronic medical records, but not for all residents. LPN 1 stated that she could also fax the order to the pharmacy. LPN 1 stated that she could also call the pharmacy with any orders. LPN 1 stated a Pyxis was available to pull medication from, and that she had the ability to access the Pyxis. LPN 1 stated that if medications were not available, she would document in the MAR, and include a note that stated she contacted pharmacy. LPN 1 stated that medications would usually arrive at the facility the same day if it was scheduled for a refill, they will put it on the next run. LPN 1 stated sometimes if the medication was not due to be reordered then it would not be refilled. LPN 1 stated that occasionally medications were misplaced or located in another cart, and she would have to locate the medication to administer it. On 9/27/22 at 2:40 PM, an interview was conducted with the DON. The DON stated that the process for reordering medication was to pull the reorder stickers from the blister pack, order through the electronic medical records, or call the pharmacy directly. The DON stated that the electronic medical records reorder was available for all residents, and that they had been training the agency staff on reordering medication for the last two weeks. The DON stated that medications were available in the Pyxis system, but not all staff had access to the medication dispensing system. The DON stated that the pharmacy was coming out this week to give access to all licensed nurses at the facility, including the agency staff. The DON stated that there was usually a nurse at the facility that had Pyxis access and the ADON lived nearby and could run over to get medication from the Pyxis for staff. The DON stated that since she had been at the facility, which was the last two weeks, she had made sure that someone was on shift who had access to the Pyxis. The DON stated that staff should contact the pharmacy to obtain a refill and notify the provider if a medication was not administered. The DON stated that the documentation was located on the MAR or in a progress note. The DON stated that the pharmacy had three deliveries a day and they were very responsive. The DON stated that she had worked a couple of shifts and the pharmacy had medication delivered within two hours yesterday. The DON stated that the licensed nurses should contact the pharmacy to obtain a refill or contact the provider to obtain a new prescription.

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	465129	A. Building B. Wing	10/03/2022

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33215 Based on interview and record review, it was determined, the facility did not ensure that each resident's drug regimen was free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose; or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Specifically, for 4 out of 34 sampled residents, a resident's beta blocker medication to treat high blood pressure was not monitored according to the physician ordered parameters. A resident's alpha-adrenergic agonists medication to treat low blood pressure was held without physician's orders. In addition, resident medications were not administered per physician's orders due to nursing staff not completing the task. Resident identifiers: 22, 30, 36, and 49. Findings included: 1. Resident 22 was admitted to the facility on [DATE] with diagnoses which included, but not limited to, nontraumatic intracerebral hemorrhage, hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, type 2 diabetes mellitus, essential hypertension, muscle weakness, and chronic pain syndrome. On 9/26/22 at 10:32 AM, an interview was conducted with resident 22. Resident 22 stated that staff were not bringing her medications timely. Resident 22 stated that she would ask for her anxiety medication and it would take along time for the staff to bring the medication. Resident 22 stated the staff would tell her there was only one nurse. Resident 22 stated that some staff were better than others. Resident 22 stated that she did not always get her diabetic medications before meals. Resident 22's medical record was reviewed on 9/27/22. The September 2022 Medication Administration Record (MAR) was reviewed. The following entries were documented: a. On 9/5/22 at 6:00 AM - 10:00 AM, Acidophilus 1 capsule was not administered due to Other Comment: Morning nurse did not administer, or complete task. b. On 9/17/22 at 4:30 PM, insulin lispro solution; 100 unit/milliliters per sliding scale was not administered due to Other Comment: Previous shift task. 2. Resident 49 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included, but not limited to, hemorrhage of anus and rectum, dementia, history of falling, type 2 diabetes mellitus with hyperglycemia, displaced fracture of second cervical vertebra, major depressive disorder, systolic congestive heart failure, secondary hypertension, and edema. Resident 49's medical record was reviewed on 9/27/22. (continued on next page)

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	465129	A. Building B. Wing	10/03/2022

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The September 2022 MAR was reviewed. On 9/5/22 at 6:00 AM - 10:00 AM, Anusol-HC (hydrocortisone acetate) suppository 25 milligrams (mg) twice a day was not administered due to Other Comment: Morning nurse did not administer, or complete task. A physician's order dated 8/12/22, documented midodrine tablet; 5 mg; Amount to Administer: 2 tabs (10 mg); oral Three Times A Day for low blood pressure. [Note: There were no physician ordered parameters to hold the midodrine.] The September 2022 MAR was reviewed. The following entries were documented when the midodrine was not administered: a. On 9/6/22 at 6:00 PM - 10:00 PM, Not Administered: On Hold Comment: B/P [blood pressure] ABOVE PARAMETERS. [Note: A B/P was not documented.] b. On 9/7/22 at 6:00 PM - 10:00 PM, Not Administered: Due to Condition. [Note: Resident 49's documented B/P was 126/70.] c. On 9/8/22 at 6:00 PM - 10:00 PM, Not Administered: Due to Condition. [Note: A B/P was not documented.] d. On 9/10/22 at 6:00 AM - 10:00 AM, Not Administered: Other Comment: outside parameters. [Note: Resident 49's documented B/P was 100/68.] e. On 9/11/22 at 6:00 PM - 10:00 PM, Not Administered: Due to Condition Comment: B/P above parameters. [Note: A B/P was not documented.] f. On 9/12/22 at 6:00 PM - 10:00 PM, Not Administered: Due to Condition [Note: Resident 49's documented B/P was 137/74.] On 9/27/22 at 2:10 PM, an interview was conducted with Licensed Practical Nurse (LPN) 1. LPN 1 stated that she would check the resident's blood pressure prior to administering the midodrine. LPN 1 stated that there were usually parameters in the physician's orders. LPN 1 stated she would contact the Medical Director if no parameters were included with the physician's order. LPN 1 stated that midodrine was administered to increase blood pressure. On 9/27/22 at 3:49 PM, an interview was conducted with the Director of Nursing (DON). The DON stated that Midodrine did not consistently have hold parameters. The DON clarified that midodrine should not be taken after the evening meal within three to four hours before bedtime. The DON stated that the evening administration time would need to be adjusted. 3. Resident 36 was admitted to the facility on [DATE] with diagnoses which included, but not limited to, viral pneumonia, chronic respiratory failure with hypoxia, pulmonary hypertension, anemia, hyperkalemia, pain, and essential hypertension. On 9/26/22 at 2:13 PM, an interview was conducted with resident 36. Resident 36 stated that her pain medication was scheduled. Resident 36 stated that most of the time she received her medications timely. (continued on next page)

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	465129	A. Building B. Wing	10/03/2022

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident 36's medical record was reviewed on 9/29/22. On 12/20/21, a Pain Interview documented that resident 36 had frequent pain the last five days. Resident 36 had a pain intensity of 5/10, and received percocet every four hours for pain management. A care plan Problem started on 7/29/22, documented Category: Pain [Name of resident 36 removed] is at risk for pain secondary to decreased mobility, hx [history] pain. The care plan interventions included: a. Created on 7/29/22, monitor pain as prescribed. b. Created on 7/29/22, offer non-pharmacological approaches to pain management. c. Created on 9/28/22, resident 36 requests to use a heat pack at times. Disposable heat packs provided to her. The September 2022 MAR was reviewed. The following entries were documented: a. On 9/24/22 at 5:00 AM, oxycodone-acetaminophen 10-325 mg every three hours was not administered due to Other Comment: Noc [night] nurse did not give. b. On 9/28/22 at 11:00 AM, oxycodone-acetaminophen 10-325 mg every three hours was not administered due to Other Comment: Last nurse did not give med. NP [Nurse Practitioner] notified. 38031 4. Resident 30 was admitted to the facility on [DATE] with diagnoses which included cerebral infarction, abscess of perineum, muscular dystrophy, hypertension, type 2 diabetes mellitus, anxiety disorder, gastro-esophageal reflux disease, major depressive disorder, and cellulitis of the buttocks. On 9/28/22, resident 30's medical record was reviewed. Review of resident 30's physician's orders revealed an order for Metoprolol tartrate tablet 100 mg by mouth one time a day. Special Instructions: Hold for systolic blood pressure (SBP) of less than (<) 100 OR diastolic blood pressure (DBP) < 60. The order was initiated on 8/2/22. Review of resident 30's September 2022 MAR revealed on 9/24/22 at 7:07 AM, the blood pressure was documented as 135/55. The Metoprolol Tartrate 100 mg was documented as administered with physician ordered parameters to hold for a SBP < 100 and a DBP of < 60. On 9/27/22 at 2:40 PM, an interview was conducted with the DON. The DON stated that she would call the NP and verify that the parameters for the Metoprolol were for DBP and not heart rate. The DON stated that based on the parameters in the order the medication should not have been administered.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465129	A. Building B. Wing	10/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Parkway Health Center	55 South Professional Way Payson, UT 84651

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38031 Based on observation, interview, and record review it was determined that the facility did not ensure that the medication error rates was not 5 percent or greater. Observations were made of 28 medication opportunities, on 9/28/22, revealed two medication errors which resulted in a 7.14 percent medication error rate. Specifically, an enteric coated Aspirin (ASA) was administered instead of a chewable and Omeprazole was substituted for Pantoprazole. Resident identifier: 53. Findings included: Resident 53 was admitted to the facility on [DATE] with diagnoses which included surgical aftercare of the digestive system, edema, type 2 diabetes mellitus, morbid obesity, obstructive sleep apnea, anxiety disorder, major depressive disorder, insomnia, hypertension, benign prostatic hyperplasia, and chronic kidney disease. Review of resident 53's physician's orders revealed the following: a. ASA tablet 81 milligrams (mg), chewable by mouth one time a day. b. Pantoprazole tablet 40 mg by mouth one time a day. On 9/28/22 at 8:15 AM, observations were made of Registered Nurse (RN) 3 during morning medication administration. RN 3 was observed to dispense and administer ASA 81 mg tablet, enteric coated (EC) and Omeprazole 20 mg tablet, two tablets to resident 53. On 9/28/22 at approximately 8:15 AM, an interview was conducted with RN 3. RN 3 confirmed that she administered ASA EC instead of a chewable. RN 3 stated that the Omeprazole was the same drug classification as Pantoprazole but was not the same drug. RN 3 was observed to look up the medication Omeprazole and stated that Omeprazole generic was Prilosec and not Pantoprazole.

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	465129	A. Building B. Wing	10/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38031 Based on observation and interview, it was determined, the facility did not ensure that all drugs and biologicals were stored in locked compartments, and were labeled in accordance with currently acceptable professional principles and included the appropriate accessory and cautionary instructions, and the expiration date when applicable. Specifically, observations were made of medications left on top of the medication cart unattended, the medication cart was observed unlocked and unattended, and medications located in the locked medication fridge were expired and still available for use. Resident identifiers: 9, 12, 29, and 53. Findings included: 1. On [DATE] at 7:38 AM, observations were made of Registered Nurse (RN) 3 during morning medication administration. RN 3 was located at the medication cart on the 400 hallway between room [ROOM NUMBER] and room [ROOM NUMBER]. RN 3 was observed to walk away from the medication cart to the nurse's station to obtain a Kleenex, leaving resident 53's dispensed medications on top of the cart and the medication cart unlocked. At approximately 8:00 AM, RN 3 entered resident 53's room to administer the morning medication. Resident 53's Fluticasone nasal spray was left on top of the medication cart while RN 3 was inside resident 53's room. On [DATE] at approximately 8:11 AM, an interview was conducted with RN 3. RN 3 stated that she normally did not walk away from the medication cart while leaving medication on top of the cart. On [DATE] at 11:03 AM, an interview was conducted with the Director of Nursing (DON). The DON stated that medication should not be left unattended and the cart left unlocked while unattended. 2. On [DATE] at 10:19 AM, the medication storage room on the ,d+[DATE] hallway was inspected. The following medications were located in the fridge with expired dates: a. Resident 9's bottle of Metoprolol suspension 10 milligrams (mg)/milliliter (ml) with approximately 110 ml remaining in a bottle of 150 ml. The expiration date was [DATE]. b. Resident 9's bottle of Metoprolol suspension 10 mg/ml with approximately 120 ml remaining in a bottle of 200 ml. The expiration date was [DATE]. c. Resident 9's bottle of Omeprazole suspension 4 mg/ml with with approximately 10 ml remaining in a bottle of 100 ml. The expiration date was [DATE]. The last number of the year was missing from the label. d. Resident 9's bottle of Omeprazole suspension 4 mg/ml with 30 ml remaining in a bottle of 100 ml. The expiration date was [DATE]. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465129	A. Building B. Wing	10/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Parkway Health Center	55 South Professional Way Payson, UT 84651

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	e. Resident 12's bottle of Lorazepam 2 mg/ml was observed with no expiration date noted on the label. f. Resident 29's bottle of Magic mouthwash suspension with 90 ml remaining in a bottle of 150 ml. The expiration date was [DATE]. g. Resident 29's bottle of Magic mouthwash suspension with approximately 125 ml remaining in a bottle of 200 ml. The expiration date was [DATE]. On [DATE] at 10:32 AM, an interview was conducted with RN 3. RN 3 stated that resident 9, resident 12, and resident 29 were still in the facility and the medication was available for use. RN 3 confirmed that the medication was either expired or did not contain an expiration date on the label. RN 3 stated that if the medication was expired they needed to discard them and reorder more. On [DATE] at 10:47 AM, an interview was conducted with the DON. The DON stated that the medication fridges should be checked weekly for expired medication, but she was not aware of who was responsible for the task.

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	465129	A. Building B. Wing	10/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide timely, quality laboratory services/tests to meet the needs of residents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38031 Based on interview and record review it was determined, for 4 of 34 sampled residents, that the facility did not provide or obtain laboratory services to meet the needs of the residents. Specifically, residents had laboratory tests ordered by the provider and the facility did not obtain them. Resident identifiers: 23, 30, 53, and 160. Findings included: 1. Resident 23 was admitted to the facility on [DATE] with diagnoses which included fracture of right femur, congestive heart failure, gastro-esophageal reflux disease, deep vein thrombosis of lower extremity, insomnia, hypothyroidism, alcohol dependence, major depressive disorder, and post-traumatic stress disorder. On 9/27/22 resident 23's medical record was reviewed. Review of resident 23's laboratory (lab) orders revealed the following: a. On 4/25/22, a Complete Blood Count (CBC) and a Comprehensive Metabolic Panel (CMP), were ordered. No documentation could be found of the laboratory reports in resident 23's medical record. b. On 4/28/22, a CBC, a CMP, and an ammonia level were ordered. No documentation could be found of the laboratory reports in resident 23's medical record. On 9/27/22 at 2:15 PM, an interview was conducted with the Corporate Minimum Data Set Coordinator (CMDSC). The CMDSC stated that stacks of lab reports were located in the Director of Nursing (DON) office and were not scanned into the resident's medical record. The CMDSC stated that another stack of records were located in the medical records office. The CMDSC stated that she did not know why the records were not scanned into each resident's electronic medical record, but they should have been. The CMDSC stated that after review of the paperwork they did not find lab results for the orders on 4/25/22 and 4/28/22, and the tests were not obtained. 2. Resident 30 was admitted to the facility on [DATE] with diagnoses which included cerebral infarction, abscess of perineum, muscular dystrophy, hypertension, type 2 diabetes mellitus, anxiety disorder, gastro-esophageal reflux disease, major depressive disorder, and cellulitis of the buttocks. On 9/28/22, resident 30's medical record was reviewed. Review of resident 30's lab orders revealed the following: a. On 3/4/22, a CBC, CMP, Thyroid Stimulating Hormone (TSH), Free Thyroxine, Hemoglobin A1C, 25-hydroxy Vitamin D, and a Vitamin B 12 were ordered. No documentation could be found of the laboratory reports in resident 30's medical record. b. On 3/25/22, a CBC, CMP, and Magnesium were ordered. No documentation could be found of the laboratory reports in resident 30's medical record. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465129	A. Building B. Wing	10/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 9/28/22 at 11:09 AM, an interview was conducted with the CMDSC. The CMDSC stated that she verified with the laboratory and the orders were not obtained. 3. Resident 53 was admitted to the facility on [DATE] with diagnoses which included surgical aftercare of the digestive system, edema, type 2 diabetes mellitus, morbid obesity, obstructive sleep apnea, anxiety disorder, major depressive disorder, insomnia, hypertension, benign prostatic hyperplasia, and chronic kidney disease. On 10/3/22, resident 53's medical record was reviewed On 9/22/22, a Vitamin D and a Parathyroid Hormone were ordered for resident 53. No documentation could be found of the laboratory reports in resident 53's medical record. On 10/3/22 at 1:42 PM, an interview was conducted with the DON. The DON stated she would locate the lab results ordered on 9/22/22. No further information or results were provided. 30563 4. Resident 160 was admitted to the facility on [DATE] and discharged on [DATE] with diagnoses which included hypertension, diabetes mellitus, and atrial fibrillation. Resident 160's medical record was reviewed on 9/29/22. A form titled Referral to Physicians and Clinics dated 3/23/22, revealed that resident 160 went to a cardiology appointment. The physician ordered to have a complete blood count, comprehensive metabolic panel, Lipids, B-type natriuretic peptide, and TSH to be obtained. In addition, the cardiologist wrote Please give Furosemide and potassium in the AM [morning] so she isn't peeing all night. A basic metabolic panel dated 3/23/22, was located in resident 160's medical record. There were no other laboratory results located. On 9/27/22 at 12:01 PM, an interview was conducted with Registered Nurse (RN) 5. RN 5 stated the laboratory came Monday and Friday to get the samples. RN 5 stated if the sample was sent to the hospital, then the nurse had to call the hospital to check because the hospital did not notify the facility staff of the results. RN 5 stated if a resident continued to complain of symptoms of a urinary tract infection, then nurses made sure a urinalysis was done and then called for results. On 9/27/22 at approximately 1:00 PM, an interview was conducted with the CMDSC. The CMDSC stated she was unable to locate laboratory results for resident 160.

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	465129	A. Building B. Wing	10/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0773 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain laboratory tests/services when ordered and promptly tell the ordering practitioner of the results. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38031 Based on interview and record review it was determined, for 2 of 34 sampled residents, the facility must obtain laboratory services only when ordered by a physician, physician assistant, nurse practitioner, or clinical nurse specialist. In addition, the facility must promptly notify the ordering physician of laboratory results that fall outside of clinical reference ranges. Specifically, a resident's laboratory (lab) tests were obtained without a provider order. In addition, a resident's urinalysis (UA) results were not obtained from the lab and reported to the ordering physician. Resident identifiers: 29 and 30. Findings included: 1. Resident 30 was admitted to the facility on [DATE] with diagnoses which included cerebral infarction, abscess of perineum, muscular dystrophy, hypertension, type 2 diabetes mellitus, anxiety disorder, gastro-esophageal reflux disease, major depressive disorder, and cellulitis of the buttocks. On 9/28/22, resident 30's medical record was reviewed. On 9/20/22, a Complete Blood Count with differential, a Comprehensive Metabolic Panel, a Thyroid Stimulating Hormone, a Vitamin B 12, a 25-hydroxy Vitamin D, and a Hemoglobin A1C were obtained. On 9/28/22 at 11:09 AM, an interview was conducted with the Corporate Minimum Data Set Coordinator (CMDSC). The CMDSC stated that she did not have a physician's order for the laboratory results that were obtained on 9/20/22. 30563 2. Resident 29 was admitted to the facility on [DATE] with diagnoses which included low back pain, injury to left lower leg, hypothyroidism, edema, chronic pain, and nausea. Resident 29's medical record was on 9/28/22. A physician's order dated 8/19/22, written by Registered Nurse (RN) 3 revealed resident 29 was to have a UA, urine culture, and urine culture and sensitivity. The Laboratory Analysis results collected on 8/19/22, and completed on 8/21/22, were reviewed. The lab results revealed resident 29 had Escherichia Coli, Peptostreptococcus prevotti, and Staphylococcus aureus. The form revealed that Macrobid 100 milligrams twice daily for five to seven days was the appropriate treatment. Resident 29's August 2022 Medical Administration Record revealed there were no antibiotics administered. There were no progress notes from 8/16/22 until 8/21/22, regarding why there was a physician's order for a UA. (continued on next page)

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	465129	A. Building B. Wing	10/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Parkway Health Center	55 South Professional Way Payson, UT 84651

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F 0773 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An Emergency provider report dated 8/21/22 at 11:48 AM, revealed Resident 29 was in increased pain over the last day or so and she coordinates this with increasing urination and dysuria. According to the lab results interpretation section resident 29 had trace of leukocyte esterase, 1-3 high power field [NAME] Blood Cells, and a few bacteria. The Discussion/Course section revealed complaints of a possible urinary tract infection (UTI) and pain radiating into the right hip and knee. The laboratory tests were fairly unremarkable. Medications administered included Ceftriaxone Sodium 1 gram on 8/21/11 at 11:51 AM, through Intravenous route. A Nurse Practitioner (NP) note dated 8/26/22, revealed that resident 29 was in pain over the weekend and she went to the hospital to have her Tramadol increased to every six hours. [It should be noted there was no information regarding resident 29's US that was collected on 8/19/22.] On 9/29/22 at 10:44 AM, an interview was conducted with the Director of Nursing (DON). The DON stated symptoms of a UTI were increased urination, frequent urination, change in vital signs, fever, and a lot more. The DON stated if a resident had symptoms the a UA would be obtained. The DON stated there should be documentation in the progress notes as to why a UA was obtained. The DON stated physicians were notified through the UA results being placed in the box for the physician when they came to the facility. The DON stated nurses also sent a tiger text to the physician with the results. The DON stated the NP was at the facility on Mondays and Thursdays and the physician on Wednesdays. The DON stated she was unable to obtain the tiger texts unless she was in on the text, so she would not be able to provide information that the physician was notified. The DON stated when the physician was notified the nurse should write a progress note. On 9/29/22 at 11:00 AM, an interview was conducted with the RN 3. RN 3 stated when a lab value or UA was ordered, she would contact the NP, an order was placed in the residents electronic medical record, and the lab company was contacted. RN 3 stated that the results of the lab were faxed to the facility or the lab contacted the NP. RN 3 stated that sometimes the lab did not send results to the facility so the nurse had to follow up with the lab. RN 3 stated if the nurse who ordered the labs was gone for a week, the nurse may not be aware of what labs had been ordered and which results had been sent to the facility. RN 3 stated the lab process had resulted in missed lab results. RN 3 stated that she tried to document in the progress notes when a lab was obtained. RN 3 stated on 8/19/22, she obtained a UA for resident 29 because she was probably acting confused or had a symptom like pain or burning when urinating. RN 3 stated she did not know if the physician was notified of the UA results. RN 3 stated she did not know if there was follow up because if it was not written in the medical record it was not done. RN 3 observed the UA results from 8/19/22, and stated it was a 6 on a scale of 1 to 7 which indicated resident 29 had an infection. RN 3 stated the results revealed resident 29 had a UTI that needed to be treated with Macrobid. RN 3 stated that things get very busy and I forget to get everything done. RN 3 stated there were not enough staff in the building. RN 3 stated there needed to be a nurse for each hallway because it's just crazy. RN 3 stated It's so stressful for me, because at the end of the day I sent the order and did not follow up on it and did not get treatment. RN 3 stated there were so many things to do that follow up with almost 40 residents was impossible to get everything done. RN 3 stated that charting did not get done. On 9/29/22 at 12:38 PM, a follow up interview was conducted with the DON. The DON stated she did not have any notes about the UA. The DON stated according to the UA in the medical record, Macrobid was the antibiotic that should have been used to treat the UTI. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465129	A. Building B. Wing	10/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Parkway Health Center	55 South Professional Way Payson, UT 84651

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F 0773 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/29/22 at 1:00 PM, an interview was conducted with resident 29. Resident 29 stated that the facility obtained a UA on 8/19/22, but she did not know the results. Resident 29 stated she got a shot at the hospital because of her UTI on 8/21/22. Resident 29 stated she was in a lot of pain at the facility, so she had to go to the hospital to get treatment. Resident 29 stated she was curious if the facility ever received the results of the UA because she had asked a bunch of times and no staff knew about the results. On 10/3/22 at 12:01 PM, an interview was conducted with the Assistant Director of Nursing (ADON). The ADON stated lab results were sent to the main fax line in the facility. The ADON stated that the physician then provided medication orders and the nurses had access to antibiotics in the Pyxus system.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465129	A. Building B. Wing	10/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Parkway Health Center	55 South Professional Way Payson, UT 84651

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 45470 Based on observations, interview, and record review it was determined, the facility did not provide food prepared by methods that conserve nutritive value, flavor, and appearance; food and drink that was palatable, attractive, and at a safe and appetizing temperature. Specifically, for 9 out of 34 sampled residents, multiple residents complained about the palatability and temperature of the food, and a sample test tray revealed that the food was not palatable. Resident identifiers: 7, 16, 20, 23, 29, 38, 45, 48, and 53. Findings Included: 1. On 9/26/22 at 11:00 AM, an interview was conducted with resident 48. Resident 48 stated that the food was getting better. Resident 48 stated that there was an alternative menu which she ordered from. Resident 48 stated she ordered a hamburger and received a bun, lettuce, cucumber, and no hamburger patty. 2. On 9/26/22 at 11:00 AM, an interview was conducted with resident 38. Resident 38 stated the food was getting better than it used to be but on the weekends the food was not good. Resident 38 stated that this last weekend the cook added white pepper to macaroni and cheese. Resident 38 stated it was too spicy and she was unable to eat it. 3. On 9/26/22 at 11:19 AM, an interview was conducted with resident 45. Resident 45 stated the food did not arrive warm. Resident 45 stated the eggs were cold and staff had to warm them up. Resident 45 stated it was not worth the time to call for assistance with the food. 4. On 9/26/22 at 11:20 AM, an interview was conducted with resident 16. Resident 16 stated the food was better but still was not good on the weekends. Resident 16 stated on Saturday night he ordered french fries and a hamburger. Resident 16 stated the kitchen sent him lasagna and a wilted salad. Resident 16 stated he asked for what he ordered, and the kitchen staff brought him a piece of sausage, bun, and lettuce. 5. On 9/26/22 at 12:30 PM, an interview was conducted with resident 23. Resident 23 stated the food needed some help. Resident 23 stated that the new cook was trying. Resident 23 stated she was tired of getting the same food every day because there was no variety. Resident 23 stated there were substitutions, but it was hard to get them after dinner was served. Resident 23 stated that sometimes there was a soup or sandwich available. 6. On 9/26/22 at 12:35 PM, an interview was conducted with resident 29. Resident 29 stated the food tasted awful. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465129	A. Building B. Wing	10/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Parkway Health Center	55 South Professional Way Payson, UT 84651

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	7. On 9/26/22 at 2:48 PM, an interview was conducted with resident 53. Resident 53 stated he needed a diabetic diet and was told he had a diabetic diet but then his hemoglobin A1c was really high. Resident 53 stated he would like better options for high protein and low carbohydrate foods. Resident 53's lunch meal was observed on his over bed table. Resident 53 had shredded chicken and gravy with no other foods. Resident 53 stated the vegetables were kind of yucky. Resident 53 stated he wished the kitchen staff served seasonal vegetables. Resident 53 stated that some of the way the vegetables were prepared were really bad so he did not usually eat them. 8. On 9/26/22 at 3:05 PM, an interview was conducted with resident 7. Resident 7 stated the food was not good. 9. A progress note dated 8/25/22 at 1:45 PM, located in resident 20's electronic medical record documented, [Resident] is seen today after he walked over to the hospital to get some lunch. He states that he does not enjoy the food at the facility, so he walked to the hospital to get some better food. On 8/29/22 at 9:55 AM, the Nurse practitioner documented, He had another episode of hypoglycemia,. Diet is very irregular, he states the food is not good so he will not eat often. On 7/14/22, resident 20's Interdisciplinary Team care plan meeting documented, food is cold and not good. 10 On 9/27/22, the Resident Council Minutes were reviewed. The Resident Council Minutes dated 9/12/22, documented, meals are still being served cold. Rolls are soggy. Meal cards are not being filled out properly. 11. On 9/27/22 at 12:13 PM, a lunch test tray was obtained. The items served for lunch were garlic marinated pork chops, orzo with lemon and herbs, basil zucchini saute, and a roll. The pork chop texture was chewy with a bland flavor. The orzo with lemon and herbs was bland, mushy, overcooked, and did not have any lemon or herb flavor. The zucchini saute was overcooked, mushy, and very bland with no seasoning. The temperature of the food on the test tray was adequate. 30563 38031

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465129	A. Building B. Wing	10/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 45470 Based on observation and interview, it was determined, the facility did not store, prepare, distribute, and serve food in accordance with professional standards for food service safety. Specifically, food items were not labeled and dated, trash was found on the floor, food splatter on the cooking equipment, and food items were left open to the air. Findings included: 1. On 9/26/22 at 10:10 AM, an initial tour of the kitchen was conducted. The following observations were made: a. A fry sauce cup and four butter packets were on the floor in the walk-in refrigerator. b. Whipped topping with no date was in the refrigerator and the label stated unopened thawed shelf life: 2 weeks. c. A white substance was on the wall by the door of the refrigerator. d. Styrofoam cups and caps to the soda machine were on the floor around the soda machine. e. Food splatter was on the front of the steamer. f. The griddle and the drawers under the griddle had food splatter. g. A cup was on the floor between the steamer and the griddle. h. The front of the stove/oven had flood splatter. i. There was dust and debris on the vents above the stove, oven, griddle, and steamer. j. Seasoned salt on top of the stove was open to air. k. There was trash outside the door that was not covered. l. The refrigerator/deli table had food splatter on it. m. A bowl of mac and cheese found in the refrigerator was dated 9/12. n. A supplement found in the refrigerator was not dated and had instructions to use within 14 days after thawing. o. Honey ham found in the refrigerator was open to air. p. Turkey breast in the refrigerator was open to air and not dated. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465129	A. Building B. Wing	10/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Parkway Health Center	55 South Professional Way Payson, UT 84651

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	q. Oven roasted turkey in the refrigerator was open to air and not dated. r. The microwave was soiled with black and brown substance on the outside. s. Ground oregano, dill weed, basil leaves, poultry seasoning, ground nutmeg, and paprika seasonings were all open to air. t. A refrigerator at the nurses station had 23 supplements with no date and had instructions to use within 14 days after thawing. 2. On 9/27/22 at 11:35 AM, a second tour of the kitchen was conducted. The following observations were made. a. A dessert cake in the walk-in refrigerator was not dated or labeled. b. Individual butter cups and onion skin was on the floor in the walk-in refrigerator. c. The walk-in freezer floor was dirty and had spilled liquid frozen to the floor. d. Styrofoam cups and caps to the soda machine were on the floor around the soda machine. e. The griddle and the drawers under the griddle had food splatter. f. Food splatter was on the front of the steamer. g. Food splatter was on the wall behind the food preparation area. h. There was dust and debris on the vents above the stove, oven, griddle, and steamer. On 9/27/22 at 12:50 PM, and interview with the Dietary Manager (DM) was conducted. The DM acknowledged the observations made in the kitchen as stated above. The DM stated that the vents above the stove, oven, griddle, and steamer were scheduled to be cleaned by the end of September 2022.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465129	A. Building B. Wing	10/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Parkway Health Center	55 South Professional Way Payson, UT 84651

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. 33215 Based on interview and record review, it was determined, the facility did not ensure that the Quality Assessment and Assurance (QAA) committee developed and implemented appropriate plans of action to correct identified quality deficiencies. Specifically, the facility was found to be in non-compliance with F584, F655, F656 and F880 which were cited within the facility's 2019 and 2021 recertification survey. The facility was also found to be in non-compliance with F755, F757, F759, and F812 which were cited within the facility's 2018, 2019, and 2021 recertification survey. In addition, the facility was found to be in non-compliance and cited at a harm level with F690, F697, F725, and F745. Findings included: An annual recertification survey was completed on 2/27/18. The following deficiencies included, but not limited to, F755, F757, F759, and F812. An annual recertification survey was completed on 4/4/19. The following deficiencies included, but not limited to, F584, F655, F656, F755, F757, F759, F812, and F880. An annual recertification survey was completed on 7/21/21. The following deficiencies included, but not limited to, F584, F655, F656, and F880. 1. Based on observation and interview, the facility did not provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. Specifically, the carpets in the facility had multiple stains and the couches were worn and had holes in the cushions. [Cross Reference F584] 2. Based on observation, interview, and record review it was determined, for 8 out of 34 sampled residents, that the facility did not develop and implement a baseline care plan for each resident that included instructions needed to provide effective and person-centered care to meet professional standards of quality care. Specifically, residents did not have a baseline care plan developed within 48 hours of admission, and the baseline care plan did not include the minimum healthcare information necessary to properly care for the residents. Resident identifiers: 8, 20, 23, 29, 44, 45, 49, and 155. [Cross Reference F655] 3. Based on observation, interview, and record review, it was determined, the facility did not develop and implement a comprehensive person-centered care plan for each resident. Specifically, for 7 out of 34 sampled resident, residents that had care areas trigger on the Minimum Data Set Care Area Assessment Summary did not have care plans developed and implemented in a timely manner. In addition, residents with identified concerns did not have care plans developed and implemented in a timely manner. Resident identifiers: 8, 20, 23, 29, 45, 49, and 53. [Cross Reference F656] (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465129	A. Building B. Wing	10/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Parkway Health Center	55 South Professional Way Payson, UT 84651

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. Based on interview and record review it was determined, for 2 out of 34 sampled residents, the facility did not ensure residents who were incontinent of bladder received appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. Specifically, a resident had a urinalysis test completed with no follow up and the resident went to hospital for treatment. In addition, a resident with signs and symptoms of a urinary tract infection went to the hospital for treatment. Resident identifiers: 29 and 44. [Cross Reference F690] 5. Based on observation, interview, and record review it was determined, for 3 out of 34 sampled residents, that 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 resident's goals and preferences. Specifically, residents complained of uncontrolled pain with no interventions or physician follow up. In addition, a resident went to the hospital in pain after pain medications were adjusted. Resident identifiers: 25, 29, and 45. [Cross Reference F697] 6. Based on observation, interview, and record review, it was determined, the facility did not have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. Specifically, for 13 out of 34 sampled residents, resident's complained of not having enough staff to meet there needs, staff complained there were not enough staff to complete their job duties, residents laboratory (lab) results were not followed up with after a urinalysis was completed, showers were not completed, residents administered their own medications because there were not enough staff, there were no grievances, residents sustained falls, resident's complained of pain, and medications were not administered according to physician's orders. Resident identifiers: 1, 7, 8, 16, 22, 23, 25, 29, 36, 38, 45, 53, and 156. [Cross Reference F725] 7. Based on interview and record review it was determined, for 1 out of 34 sampled residents, that the facility did not provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being. Specifically, a resident had expressed desires to die by refusal of treatment for diabetes and was not evaluated and seen by social services. Resident identifier: 20. [Cross Reference F745] 8. Based on interview and record review, it was determined, that the facility did not provide routine and emergency drugs and biologicals to its residents. Specifically, for 7 out of 34 sampled residents, resident medications were not administered as ordered by the physician due to the medications not being available by the pharmacy. Resident identifiers: 22, 23, 29, 30, 49, 53, and 160. [Cross Reference F755] (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465129	A. Building B. Wing	10/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Parkway Health Center	55 South Professional Way Payson, UT 84651

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	9. Based on interview and record review, it was determined, the facility did not ensure that each resident's drug regimen was free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose; or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Specifically, for 4 out of 34 sampled residents, a resident's beta blocker medication to treat high blood pressure was not monitored according to the physician ordered parameters. A resident's alpha-adrenergic agonists medication to treat low blood pressure was held without physician's orders. In addition, resident medications were not administered per physician's orders due to nursing staff not completing the task. Resident identifiers: 22, 30, 36, and 49. [Cross Reference F757] 10. Based on observation, interview, and record review it was determined that the facility did not ensure that the medication error rates was not 5 percent or greater. Observations were made of 28 medication opportunities, on 9/28/22, revealed two medication errors which resulted in a 7.14 percent medication error rate. Specifically, an enteric coated Aspirin was administered instead of a chewable and Omeprazole was substituted for Pantoprazole. Resident identifier: 53. [Cross Reference F759] 11. Based on observation and interview, it was determined, the facility did not store, prepare, distribute, and serve food in accordance with professional standards for food service safety. Specifically, food items were not labeled and dated, trash was found on the floor, food splatter on the cooking equipment, and food items were left open to the air. [Cross Reference F812] 12. Based on observation and interview, it was determined, the facility did not 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, observations were made during a meal service and assisted dining without hand hygiene being performed. Additionally, observations were made of bare handed contact during medication dispensing and administration. Resident identifiers: 3, 6, 12, 23, and 53. [Cross Reference F880] On 10/3/22 at 11:32 AM, an interview was conducted with the Administrator. The Administrator stated they facility held a QAA meeting monthly, and the Administrator ensured the Medical Director (MD) was there at least quarterly, but the Administrator would try to get the MD to attend as much as he could. The Administrator stated that pretty much all the department head teams would attend. The Administrator stated that he would have each department bring issues to the QAA meeting and the team would run a root cause analysis for each of the problems, then come up with a plan to solve the issue at the root of the problem. The Administrator stated the team would do a root cause analysis for each department. The Administrator stated that the team would also pull quality measures. The Administrator stated the nursing department was based on quality measures, so that would cover falls, infections, and wounds.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465129	A. Building B. Wing	10/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Parkway Health Center	55 South Professional Way Payson, UT 84651

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38031 Based on observation and interview, it was determined, the facility did not 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, observations were made during a meal service and assisted dining without hand hygiene being performed. Additionally, observations were made of bare handed contact during medication dispensing and administration. Resident identifiers: 3, 6, 12, 23, and 53. Findings included: 1. On 9/26/22, the following observations were made during the lunch meal service by Certified Nurse Assistant (CNA) 2: a. At 12:01 PM, CNA 2 delivered the meal tray to resident 6. CNA 2 did not perform hand hygiene prior to or after delivery of the food tray. b. At 12:01 PM, CNA 2 delivered resident 3's tray to the dining room table. Resident 3 was not seated at the table. CNA 2 placed a straw in the cup of milk touching the tip of the straw with bare hands, and then uncovered the plate of food. The dessert was observed uncovered. CNA 2 did not perform hand hygiene. c. At 12:03 PM, CNA 2 delivered the meal tray to room [ROOM NUMBER]-2. CNA 2 was observed to move a grabber tool and water mug on the bedside table. CNA 2 then placed the meal tray on the bedside table, removed the meal ticket from the tray, and placed it at the nurse's station. CNA 2 did not perform hand hygiene upon exit of the room. d. At approximately 12:05 PM, CNA 2 was observed to walk to the kitchen. CNA 2 was observed to open a door leading to the kitchen hallway. CNA 2 then entered the kitchen, walked past the food prep/service area and entered the fridge to obtain a peanut butter and jelly sandwich. CNA 2 was not wearing a hair net when entering the kitchen. e. At 12:07 PM, CNA 2 delivered the meal tray to room [ROOM NUMBER]. CNA 2 was observed to move and adjust the height of the bedside table. CNA 2 did not perform hand hygiene upon exit of the room. f. At 12:09 PM, CNA 2 delivered resident 23's meal tray to the dining room table. CNA 2 placed a straw in the cup of milk touching the tip of the straw with bare hands. The dessert was observed uncovered. CNA 2 did not perform hand hygiene. g. At 12:10 PM, CNA 2 provided dining assistance to resident 12. CNA 2 was observed to provide resident 12 with a bite of potatoes. CNA 2 did not perform hand hygiene. It should be noted that during the entire meal tray delivery and dining assistance CNA 2 did not perform hand hygiene. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465129	A. Building B. Wing	10/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Parkway Health Center	55 South Professional Way Payson, UT 84651

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 9/27/22 at 12:05 PM, an observation of the lunch service was observed. The food cart which contained resident food trays was placed at the nurse's station between the 100 and 200 halls. Staff members were observed carrying the lunch trays from the nurse's station through the hallway to the resident rooms. The main course and the drinks were observed to be covered. The brownie dessert on the resident food trays were not covered. On 10/3/22 at 3:53 PM, an interview was conducted with CNA 8. CNA 8 stated that hand hygiene should be performed after all meal trays were passed. CNA 8 stated that hand hygiene should also be performed between tray delivery if items were touched in the environment. CNA 8 stated that all food items coming off the meal cart should be covered. CNA 8 stated that they were allowed inside the kitchen but if they passed the yellow line they needed to put on a hair net. 2. On 9/28/22 at 7:38 AM, observations were made of Registered Nurse (RN) 3 during morning medication administration for resident 53. RN 3 was observed to dispense two tablets of Omeprazole into their bare hand and then placed inside a cup with their fingers. At 8:11 AM, an interview was conducted with RN 3. RN 3 stated that she tried not to bare handed touch the medication, but she did occasionally have to touch pills. On 9/29/22 at 11:03 AM, an interview was conducted with the Director of Nursing (DON). The DON stated that medications should not be touched with bare hands by staff. 45470

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465129	A. Building B. Wing	10/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Parkway Health Center	55 South Professional Way Payson, UT 84651

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38031 Based on interview and record review it was determined, for 1 out of 34 sampled residents, the facility did not establish an infection prevention and control program that included antibiotic use protocols and a system to monitor antibiotic use. Specifically, a resident was receiving a prophylactic antibiotic without a diagnosis to treat. Resident identifier: 53. Findings included: Resident 53 was admitted to the facility on [DATE] with diagnoses which included surgical aftercare of the digestive system, edema, type 2 diabetes mellitus, morbid obesity, obstructive sleep apnea, anxiety disorder, major depressive disorder, insomnia, hypertension, benign prostatic hyperplasia, and chronic kidney disease. On 10/3/22, resident 53's medical record was reviewed. Review of resident 53's physician's orders revealed an order for Macrobid capsule 100 milligrams by mouth at bedtime. The order was initiated on 8/1/22. No documentation could be found for the rationale for the use of the prophylactic antibiotic Macrobid. On 10/3/22 at 2:47 PM, an interview was conducted with the Director of Nursing (DON). The DON stated she was still looking for the rationale for the use of the Macrobid. No additional information was provided by the DON for the prophylactic antibiotic.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465129	A. Building B. Wing	10/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Parkway Health Center	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.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. 33215 Based on interview and record review, it was determined, the facility did not ensure that each resident's medical record included documentation that indicated that the resident or resident's representative was provided education regarding the benefits and potential side effects of the influenza and pneumococcal immunizations; and that the resident either received the influenza and pneumococcal immunizations or did not receive the influenza and pneumococcal immunizations due to medical contraindications or refusal. Specifically, for 1 out of 34 sampled residents, a resident's pneumococcal vaccine was not documented as administered after the resident's responsible party consented to the pneumococcal vaccine. Resident identifier: 10. Findings included: Resident 10 was admitted to the facility 6/8/22 with diagnoses which include, but not limited to, cerebral infarction, gastrointestinal hemorrhage, delirium die to known physiological condition, essential hypertension, and chronic diastolic congestive heart failure. Resident 10's medical record was reviewed on 10/3/22. A Consent To Administer Pneumococcal Vaccine was reviewed. Resident 10's responsible party gave verbal consent to receive the vaccination. A physician's order dated 6/8/22, documented Pneumococcal Vac [vaccine] Polyvalent Injectable Inject 0.5 ml [milliliters] intramuscularly as needed for Pneumo [Pneumococcal] Vacc [vaccine]. The June, July, August, and September 2022 Medication Administration Records were reviewed. The Pneumococcal vaccine was not documented as administered to resident 10. On 10/3/22 at 1:54 PM, an interview was conducted with the Director of Nursing (DON). The DON stated the staff should be completing the immunization consents on admission. The DON stated the vaccine should be administered at the time the consent was signed.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465129	A. Building B. Wing	10/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Parkway Health Center	55 South Professional Way Payson, UT 84651

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33215 Based on interview and record review, it was determined, the facility did not ensure the resident's medical record included documentation that indicates, at a minimum, the following: that the resident or resident representative was provided education regarding the benefits and potential risks associated with Coronavirus Disease-2019 (COVID-19) vaccine; each dose of COVID-19 vaccine administered to the resident; or if the resident did not receive the COVID-19 vaccine due to medical contraindications or refusal. Specifically, for 4 out of 34 sampled residents, the facility did not provide the resident or resident representative with education of the benefits and potential risks associated with the COVID-19 vaccination. In addition, the resident's medical record did not include documentation regarding the residents' COVID-19 vaccination refusal or acceptance. Resident identifiers: 10, 13, 45, and 49. Findings included: 1. Resident 13 was admitted to the facility on [DATE] with diagnoses which included, but not limited to, hemiplegia affecting right dominant side, essential hypertension, and type 2 diabetes mellitus. Resident 13's medical record was reviewed on 10/3/22. A review of the Immunization section of the medical record revealed no documentation regarding resident 13's COVID-19 immunization status. No documentation was located indicating that resident 13 or the resident representative was provided education regarding the benefits and potential risks associated with the COVID-19 vaccination. 2. Resident 45 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included, but not limited to, major depressive disorder, adult failure to thrive, unspecified abdominal pain, anemia, opioid dependence, and anxiety disorder. Resident 45's medical record was reviewed on 10/3/22. A review of the Immunization section of the medical record revealed no documentation regarding resident 45's COVID-19 immunization status. No documentation was located indicating that resident 45 or the resident representative was provided education regarding the benefits and potential risks associated with the COVID-19 vaccination. 3. Resident 10 was admitted to the facility 6/8/22 with diagnoses which include, but not limited to, cerebral infarction, gastrointestinal hemorrhage, delirium die to known physiological condition, essential hypertension, and chronic diastolic congestive heart failure. Resident 10's medical record was reviewed on 10/3/22. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465129	A. Building B. Wing	10/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Parkway Health Center	55 South Professional Way Payson, UT 84651

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the Immunization section of the medical record revealed no documentation regarding resident 10's COVID-19 immunization status. No documentation was located indicating that resident 10 or the resident representative was provided education regarding the benefits and potential risks associated with the COVID-19 vaccination. 4. Resident 49 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included, but not limited to, hemorrhage of anus and rectum, dementia, history of falling, type 2 diabetes mellitus with hyperglycemia, displaced fracture of second cervical vertebra, major depressive disorder, systolic congestive heart failure, secondary hypertension, and edema. Resident 49's medical record was reviewed on 9/27/22. A review of the Immunization section of the medical record revealed no documentation regarding resident 49's COVID-19 immunization status. No documentation was located indicating that resident 49 or the resident representative was provided education regarding the benefits and potential risks associated with the COVID-19 vaccination. On 10/3/22 at 1:54 PM, an interview was conducted with the Director of Nursing (DON). The DON stated the staff should be completing the immunization consents on admission. The DON stated the vaccine should be administered at the time the consent was signed.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465129	A. Building B. Wing	10/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Parkway Health Center	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.

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F 0888 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure staff are vaccinated for COVID-19 33215 Based on interview and record review, it was determined, the facility did not ensure that all staff including contracted staff were fully vaccinated for Coronavirus Disease-2019 (COVID-19), except for those staff who had been granted exemptions to the vaccination. Specifically, for 2 out of 8 sampled staff members (SM), who were not temporarily delayed, had not completed the vaccination series for a multi-dose COVID-19 vaccine. Staff identifiers: SM 1 and SM 2. Findings included: 1. The COVID-19 Staff Vaccination Status for Providers was reviewed. The following were documented: a. SM 1 had received one dose of the Pfizer COVID-19 vaccine on 1/11/22. b. SM 2 had received one dose of the Pfizer COVID-19 vaccine on 2/4/21. [Note: Staff members were not fully vaccinated and did have a pending or granted exemption or a temporary delay per the Centers for Disease Control and Prevention.] On 10/3/22 at 10:47 AM, an interview was conducted with SM 1. SM 1 stated that she had received the first dose of a COVID-19 vaccine on 1/11/22. SM 1 stated that she had not received the second dose of a COVID-19 vaccine yet. SM 1 stated that she had contracted COVID-19 three days after the first dose was administered. SM 1 stated that she was told there would be a wait period before she could get the second dose of a COVID-19 vaccine. SM 1 stated that she had been cleared and just had not gotten the shot. On 10/3/22 at 10:59 AM, an interview was conducted with the ADON. The ADON stated that himself and the prior DON would work as a team to ensure the staff were vaccinated. The ADON stated that he was unsure if the current DON was assisting with the vaccination effort. The ADON stated that the Human Resources Director (HRD) would ask the new hire staff what their vaccination status was. The ADON stated that the HRD would track the COVID-19 vaccination status of staff and would report to the State. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465129	A. Building B. Wing	10/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Parkway Health Center	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)
F 0888 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/3/22 at 11:42 AM, an interview was conducted with the HRD. The HRD stated when the new hire staff came in for on boarding she would get a copy of their COVID-19 vaccination card. The HRD stated if the staff member was not vaccinated for COVID-19 she would have the staff member complete the exemption form. The HRD stated the exemption form was sent to the corporate Human Resources and they would approve the exemptions. The HRD stated that she would check in with the staff that were employed by the facility and tracked updates regarding the COVID-19 vaccine. The HRD stated that she would usually check in with staff every month or so but there was no time line. The HRD stated that she had been trying to work on getting SM 2's COVID-19 vaccination. The HRD stated that when she first asked SM 2 about the COVID-19 vaccination the HRD tried to get SM 2 to complete the exemption form but SM 2 did not want to complete the exemption form. The HRD stated that SM 2 told her that she would just get the COVID-19 vaccination. The HRD stated that SM 2 still had not completed the second dose of a COVID-19 vaccine or the exemption. The HRD stated that she would check in with SM 2 today and encourage SM 2 to either complete the exemption form or get the second dose of a COVID-19 vaccine.