| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 165147 | A. Building<br>B. Wing | 06/10/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Park Place | 401 South Van Buren<br>Mount Pleasant, IA 52641 |

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 0689<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, policy review, and staff interview, the facility failed to implement care plan interventions to prevent a fall with a major injury for 1 of 3 residents (Resident #2) reviewed with a high fall risk. The facility reported a census of 34 residents.Findings include:The Minimum Data Set (MDS) assessment tool dated 4/8/26, listed Resident #2 diagnoses, which included the presence of a left artificial knee joint, osteoarthritis (inflammation of the bones and joints), and heart failure. The MDS identified that the resident depended on staff for toileting hygiene, toilet transfers, and chair transfers. The Brief Interview for Mental Status (BIMS) score of 15 out of 15, indicated intact cognition. The MDS listed an admission date of 12/29/23. The MDS documented Resident #1 discharged on 4/8/26 for a short-term hospital stay. Review of a hospital Discharge Noted dated 4/29/26, Summary of Events Leading to admission section revealed, in part.admitted to [name of hospital redacted] following a fall [NAME] resulted in a closed, comminuted, intra-articular distal femur fracture (a broken thigh bone just above the knee) adjacent to her left knee prosthesis. She underwent retrograde intramedullary nailing with cable cerclage (type of procedure completed - use of metal rod into the center of bone and wrapping of cables around outside the bone to hold fractured fragments in place) for surgical fixation on 4/10/26.Care Plan entries dated 6/3/25, revealed the resident would not sustain any bony injury from a fall and directed staff to ensure the call light was within reach. A Morse Fall scale dated 2/25/26 indicated Resident #2 at high risk for falls. Review of a documents titled Patient Event [facility name redacted] Fall Form revealed:a. On 4/8/26 the resident's call light was not in reach and she attempted to get up unassisted from the recliner. The form indicated the event occurred at 1:35 p.m. and the resident was last toileted at 7:00 a.m. Another resident's visitor called the nurse to her room and the resident was on her knees leaning towards the bed with her head resting on the bed. The resident asked where her call light was. The resident sustained a spiral fracture to the left femur (thigh bone) and transferred to the hospital. The form stated the actual or potential most likely severity of injury associated with this event was major permanent lessening of bodily functioning not related to underlying conditions. b. On 6/6/26 the resident got up unattended and her call light was not in reach. The report stated the facility re-educated staff regarding call light placement. Review of a Performance Management Memo dated 4/10/26 documented Staff A, Certified Nursing Assistant (CNA) provided care to a resident on 4/8/26 and the resident's call light was not within the resident's immediate reach following care interactions. As a result, the resident was unable to summon assistance and fell from the recliner, sustaining a major injury. Staff A received a written warning.Review of a Performance Management Memo dated 4/10/26 documented stated Staff B, Registered Nurse (RN) provided care to a resident on 4/8/26 and the resident's call light was not within the resident's immediate reach following care interactions. As a result, the resident was unable to summon assistance and fell from the recliner, sustaining a major injury. Staff B received a written warning.During an interview on 6/9/26 at 11:37 a.m., Staff A, CNA stated she assisted the resident to her chair around 9:00 a.m. on the day of the fall [4/8/26]. She stated she did not recall where the call light was when she left the room but stated staff usually<br>(continued on next page) |

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

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

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| F 0689<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | clipped it to her.During an interview on 6/9/26 at 11:51 a.m. Staff B, RN stated on the day of the fall [4/6/26], another resident's visitor alerted her that the resident was on the floor. She stated the resident asked where her call light was. Staff B stated the call light was not in reach but clipped to itself (hanging down from the wall). Staff B stated the resident reported that her leg was broken. The resident left the facility for x-rays and then admitted to the hospital. Staff B stated prior to the fall she saw the resident around lunchtime when she gave her medications. She stated she didn't remember giving the resident her call light and stated she received disciplinary action due to this. During an interview on 6/10/26 at 9:44 a.m., the Director of Nursing (DON) stated on the day the resident fell [4/8/26], she did not have her call light. She stated she spoke with all individuals who took care of the resident that day and carried out disciplinary actions due to the staff not ensuring the resident had her call light.On 6/10/26 at 9:20 a.m., via email, the Administrator stated the facility did not have a written policy related to fall prevention. The facility policy Baseline Care Plan Policy, dated 8/2021, stated staff would implement interventions to assist the resident to achieve care plan goals and objectives. |