STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165147	A. Building B. Wing	05/22/2025

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

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** Based on observation, review of Resident Council Meeting minutes, review of Call Light Logs, clinical record review, resident, resident family member, and staff interviews, the facility failed to ensure staff responded to call lights within in 15 minutes for 5 of 5 residents reviewed for call lights (Residents #3, #15, #38, #14 and #18). The facility reported a census of 38 residents. Findings include: Review of April 2025 Resident Council Meeting minutes, dated 4/23/25, revealed the following comments: One resident mentioned that it seems as though the call light response times have improved, except on weekends. Another resident disagreed with the wait time improvement and remarked that she still has to wait for extended periods for her call light to be answered. 1. Review of the Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #3 scored 12 out of 15 on a BIMS exam, which indicated a moderately impaired cognition. The MDS list of diagnoses included heart failure, stroke, and urine retention. The MDS indicated Resident #3 dependent on staff for transfers to the toilet and maximum assistance with toileting hygiene. Review of the Call Light Log for Resident #3 from 5/6/2025 to 5/19/25 revealed: a. On 5/06/25, the resident's call light on for 22 minutes before staff responded. b. On 5/10/25, the resident's call light on for 19 minutes before staff responded. c. On 5/11/25, the resident's call light on for 22 minutes before staff responded. d. On 5/12/25, the resident's call light on for 21 minutes before staff responded. e. On 5/13/25, the resident's call light on for 19 minutes before staff responded. f. On 5/14/25, the resident's call light on for 38 minutes before staff responded. g. On 5/16/25, the resident's call light on for 22 minutes before staff responded. h. On 5/17/25, the resident's call light on for 1 hour and 31 minutes before staff responded. (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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	i. On 5/18/25, the resident's call light on for 1 hour and 12 minutes before staff responded. j. On 5/19/25, the resident's call light on for 23 minutes before staff responded. A continuous observation on 05/20/25 starting at 11:19 AM and ending at 11:56 AM revealed: a. At 11:19 AM, Resident #3 sat in his wheelchair at the entrance to his room. Resident #3 stopped Staff A, Certified Nurses Aide (CNA) in the hall and requested assistance with going to the toilet. Staff A told Resident #3 she would come back with the machine [mechanical lift device] and another staff to transfer the resident. b. At 11:25 AM, Resident #23 stopped and ask Resident #3 if he needed something. Resident #3 said he needed to use the toilet. Resident #23 stopped Staff B, CNA, and told Staff B that Resident #3 needed assistance. Staff B, CNA said that she knew and staff were coming. Staff B said that she had to go check on the alarm and walked to the west hallway to the sound of an alarm. c. At 11:27 AM, Staff B, CNA went by Resident #3 and said staff were coming. Resident #3 reiterated that he had to go to the toilet. d. At 11:29 AM, Staff C, Housekeeper, walked by Resident #3 who continued to sit in his wheelchair at the entrance to his room. Staff C asked Resident #3 if he was going to go to lunch. Resident #3 responded that he was waiting for staff to help him, and that he had been waiting for 20 minutes. e. At 11:33 AM, Staff B, CNA, informed Staff D, CNA, that she was going on break. Staff B, CNA, told Staff D, CNA, that she could help, but had not had a break yet. Staff D, CNA, told her to go ahead and go on break. f. At 11:36 AM, Staff D, CNA, asked Staff A over a communication device to meet her in Resident #3's room. Staff D, CNA then saw Resident #28 walking down the hallway with her walker, and stopped to help Resident #28 into her room. Staff D entered the room with Resident #28 and shut the door. g. At 11:40 AM, Staff A, CNA, pushed a resident in their wheelchair down the hall to the dining room. Staff D, CNA, came out of Resident #28's room and went down the west hall. h. At 11:41 AM, Staff D, CNA, came down the hall with a stand lift and entered Resident #3's room with Staff A, CNA. Resident #3 waited 22 minutes for assistance. f. At 11:44 AM, Staff A, CNA, exited Resident #3's room and told Staff D, CNA, to let her know when the resident was ready to transfer back to the wheelchair. She confirmed that she just helped transfer Resident #3 to the toilet. g. At 11:56 AM, Staff D, CNA, and Staff A, CNA exited Resident #3's room. Staff D, CNA, reported Resident #3 was continent and had used the toilet to urinate. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 5/21/25 at 2:30 PM, Staff F, Certified Nurses Aide (CNA), reported she worked third shift and also picked up second shifts. Staff F, CNA, explained that when a resident used their call light, any staff could respond to help the resident no matter what hall facility management had assigned them. Once a staff person indicated they accepted the call light, all other staff received a phone notification which identified which staff person responded. Staff then went to the resident's room and reset the call light button, assisted the resident, marked complete on their phone and documented the reason for the call light. Staff F, CNA, reported she had responded to residents' call lights, went to the room and shut the light off, and then told the resident that she would be back. Staff F, CNA, explained that she would shut of the call light, because the call lights were timed. Staff F, CNA, reported the busiest times were in the morning when everyone was trying to get up and after dinner when everyone wanted to go to bed. Staff F, CNA, explained that residents that needed assistance with transfers, but could wheel themselves to their rooms, might have to wait awhile, longer than 15 minutes, to get assistance. Staff F, CNA, further explained that staff had to clear the dining room of residents first before assisting residents with cares due to risks of choking hazard and falls. During an interview on 5/21/25 at 2:36 PM Staff G, CNA, reported she worked on second shift. Staff G, CNA, reported that she has answered residents' call lights, reset the call light, and told the resident she would be back. Staff G, CNA, explained that if she was busy trying to help other residents, and if the resident needed to go to the bathroom, she would assist the resident, but if they only needed something like water, she would tell them she would be back. Staff G, CNA, reported the busy time in the evening was right after dinner, because everyone wanted to go to bed. Staff G, CNA, explained sometimes people had to wait for assistance while staff got everyone out of the dining room. Staff G, CNA, did not know how long residents had to wait. During an interview on 05/22/25 at 11:24 AM, Staff I, CNA, reported she worked day shift and had worked at the facility for about 18 years. She reported that staff response time to call lights was usually really quick. Staff I reported after lunch was the busiest time. There were some residents that might have to wait a while for assistance while staff got everybody out of the dining room, but Staff I still did not think that the call light response time was very long. Staff I reported that she had not gone to a resident's room and shut the call light off without helping the resident, unless the resident denied that they needed help right away and said they could wait. If the resident could wait, Staff I explained she would shut the call light off and she would get back to that resident as quickly as possible. 3. The MDS assessment dated [DATE] revealed Resident #38 scored a 15 out of 15 on the BIMS exam, which indicated cognition intact. The MDS indicated the resident needed substantial/maximal assistance with toileting hygiene and needed partial/ moderate assistance with personal hygiene, lower body dressing, and put on and taking off footwear. During an interview on 5/19/25 at 11:09 AM, Resident #38 queried on the call light response and he stated sometimes it took 40 minutes. Resident #38 asked how that made him feel and he stated he would get upset, especially when he needed assistance with his ostomy. Review of the Call Light Log for Resident #39 from 5/6/25 to 5/19/25 revealed: a. On 5/06/25, the resident's call light on for 23 minutes before staff responded. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	b. On 5/07/25, the resident's call light on for 1 hour and 23 minutes before staff responded. c. On 5/08/25 at 8:08 AM, the resident's call light on for 20 minutes before staff responded. d. On 5/08/25 at 10:15 AM, the resident's call light on for 26 minutes before staff responded. e. On 5/09/25, the resident's call light on for 22 minutes before staff responded. f. On 5/11/25, the resident's call light on for 20 minutes before staff responded. g. On 5/12/25, the resident's call light on for 1 hour and 16 minutes before staff responded. h. On 5/13/25, the resident's call light on for 25 minutes before staff responded. i. On 5/15/25, the resident's call light on for 28 minutes before staff responded. j. On 5/16/25, the resident's call light on for 1 hour and 29 minutes before staff responded. k. On 5/17/25, the resident's call light on for 32 minutes before staff responded. l. On 5/18/25, the resident's call light on for 44 minutes before staff responded. m. On 5/19/25, resident's call light on for 1 hour and 2 minutes before staff responded. 4. Review of the MDS assessment dated [DATE], revealed Resident #14 scored a 15 out of 15 on the BIMS exam, which indicated cognition intact. The MDS indicated impairment in one upper extremity and both of the lower extremities. The MDS revealed substantial/maximal assistance with toileting hygiene, upper and lower body dressing. The MDS revealed the resident required partial/moderate assistance with sitting to stand; chair/bed to chair transfer, and toilet transfer. The MDS indicated resident occasionally incontinent of urine. The MDS indicated medical diagnoses for unspecified osteoarthritis and spinal stenosis. The MDS revealed the resident took a diuretic. During an interview on 5/19/25 at 9:45 AM, Resident #14 queried on call light response and she stated she puts her light on at a quarter til 7 in the morning and waited at least a half an hour for assistance. Resident #14 stated the day before, she waited almost an hour for someone to answer her call light after one of her meals. Resident #14 stated there were times she didn't make it to the bathroom on time because she had to wait for staff to come and help Resident #14. Resident #14 stated she didn't like being helpless and needing help. Resident #14 stated she knew how long she had to wait because she looked at her watch to see how long it took. Review of the Call Light Log for Resident #14 from 5/7/25 to 5/19/25 revealed: a. On 5/07/25, the resident's call light on for 21 minutes before staff responded. b. On 5/10/25, the resident's call light on for 28 minutes before staff responded. c. On 5/11/25 at 7:15 AM, the resident's call light on for 24 minutes before staff responded. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	d. On 5/11/25 at 10:12 AM, the resident's call light on for 29 minutes before staff responded. e. On 5/15/25, the resident's call light on for 25 minutes before staff responded. f. On 5/16/25, the resident's call light on for 37 minutes before staff responded. g. On 5/18/25, the resident's call light on for 51 minutes before staff responded h. On 5/19/25, the resident's call light on for 26 minutes before staff responded. 5. Review of the MDS assessment dated [DATE], revealed Resident #18 scored a 6 out of 15 on the BIMS exam, which indicated cognition severely impaired. The MDS indicated impairment on one upper and lower extremity. The MDS revealed resident dependent with toileting hygiene, lower body dressing, putting on/taking off footwear, personal hygiene, roll left to right; sit to lying, lying to sitting on bedside, sit to stand, and chair/bed to chair transfer. The MDS indicated resident always incontinent of bowel and bladder. The MDS revealed medical diagnoses of non-Alzheimer's dementia. During an interview dated 5/19/25 at 10:14 AM, a family member of Resident #18's queried about call light response and she stated she thought the facility was short staffed because sometimes Resident #18 waited 40 minutes for help. The family member stated it upset her and Resident #18 waiting for assistance. The family member stated she looked at her watch to know how long Resident #18 waited. Review of the Call Light Log for Resident #18 from 5/11/25 to 5/12/25 revealed: a. 5/11/25, the resident's call light on for 42 minutes before staff responded. b. 5/12/25, the resident's call light on for 39 minutes before staff responded. During an interview on 5/22/25 at 1:53 PM, the Director of Nursing (DON) stated the facility put in a new call light system and she didn't believe all the times on reports were correct. The DON stated if a staff member clicked they would answer the light, that staff member was the only person who could close it on the system. The DON stated call lights were always a topic at the all staff meetings. The DON stated she printed off the call light reports for the staff to review. The DON stated call lights discussed at the resident council and the DON and the Administrator attended the meeting and explained the new system to the residents. The DON stated she encouraged the residents to push their call light if staff turned it off and said they would be back. The DON stated she received complaints from the residents about call light response during care conference meetings. The DON stated the she expected the call lights to be answered within 20 minutes. During an interview on 5/22/25 at 2:25 PM, the Administrator stated they were talking about developing a Quality Assurance Performance Improvement (QAPI) for call lights because they were an issue. The Administrator confirmed the call lights are on longer than they should and the residents discussed it at resident council. Per email from the DON on 5/22/25 at 3:38 PM, the facility lacked a policy for call lights.