STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165345	A. Building B. Wing	05/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Parkridge Specialty Care	5800 NE 12th Avenue Pleasant Hill, IA 50327

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 0684 Level of Harm - 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** 44512 Based on clinical record review, facility policy review, family, resident interviews, and staff interviews, the facility failed to promptly identify and intervene for an acute change in a resident's condition, chest pain, shortness of breath, cough and urinary incontinence related to fluid volume overload. As a result the family transported the resident to the emergency department. Resident #1 was admitted to the hospital with acute hypoxic (lack of oxygen) respiratory failure due to pulmonary edema (excessive fluid in the lungs), sinus bradycardia (slowing of the heart), acute diastolic heart failure and swelling in the scrotum due to the edema. Concerns were identified for 1 or 3 residents reviewed for assessment and intervention. (Resident#1). The facility reported a census 81 of residents. Findings include: The Admission Minimum Data Set (MDS) dated [DATE] for Resident #1 revealed the diagnosis of atrial fibrillation (dysrthythmia of the heart), dementia, depression, alcohol abuse The MDS documented that the resident required supervision from 1 staff member for bathing but was independent with functional abilities, the resident had occasional urinary incontinence. Resident #1's had a Brief Interview for Mental Status (BIMS) score of 13 which suggested an intact cognition. The Care Plan failed to provide direction for staff regarding the dysrthymia of the heart and for weight gain. During an interview on 5/9/24 at 1:09 p.m., The Power of Attorney (POA) for the resident reported the facility staff called her on 4/22/24 to report the resident was congested and received an over the counter (OTC) nasal spray and cough medication. The POA stated on 4/26/24 she visited the resident and he didn't look good, stated he was short of breath, had urinated all over and this was reported to staff before leaving the center. She returned the next morning to find the resident in the same condition, He looked bad and couldn't breathe. The POA stated she changed his clothes and told the staff she was taking him to see a doctor and went to the emergency department where he was immediately placed on oxygen. The POA stated that when she returned to the facility to gather some clothes, the staff wanted to know why she took him to the hospital. The POA stated she told the staff that he was admitted to the hospital. Hospital record; History and Physical dated 4/27/24, for Resident #1 documented the following; (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 0684 Level of Harm - Actual harm Residents Affected - Few	a. Chest pain, shortness of breath, cough and urinary incontinence with hypoxic oxygen saturation of 85% (typical healthy reading is 95 - 100%). b. Cardiologist consulted and applied transcutaneous pacing (external pacing for bradycardia). c. Scrotal cellulitis (inflammation of the scrotum) treated with IV antibiotics. d. admitted to the intensive care unit on telemetry (continuous heart monitoring). On 5/14/24 at 10:24 a.m. Resident #1 stated he informed the staff that he did not feel well and was not assessed by a nurse and his daughter transported him to the hospital for an evaluation. During an interview on 5/14/24 at 10:42 a.m. Staff A, Certified Nursing Assistant (CNA) stated, A couple of days before he went to the hospital he (Resident #1) had a cough and I told the nurse. During an interview on 5/14/24 at 1:08 p.m. Staff B, Certified Nursing Assistant (CNA) stated Resident #1 was not feeling well before going to the hospital. Staff B stated Resident #1 refused to eat and refused to get out of bed as he was not feeling well. During an interview on 5/15/24 at 1:22 p.m. Staff E, Advanced Practice Registered Nurse (APRN), reported that the facility nurse had called the on-call practitioner on 4/21/24 and received an order for a nasal spray. Staff E stated she had visited Resident #1 the next day, discontinued the nasal spray and ordered Flonase. Staff E stated the facility nurse did not inform her of a weight gain nor difficulty breathing. Staff E stated I was told he had a cold. Staff E stated that she was not informed that Resident #1's condition had declined after her visit. Staff E stated, If it affects the ABC's (Airway, Breathing or Circulation), they should call me. On 5/14/24 at 12:20 PM, Staff D, Assistant Director of Nursing (ADON) stated she worked on 4/26/24 and had visualized Resident #1 in the front lobby area in a chair with several staff around him. Staff D stated that no one had alerted her that Resident #1 was not well and she was the on-call nurse that weekend. Staff D stated the daughter transported Resident #1 to the hospital on 4/27/24. During an interview on 5/15/24 at 1:45 p.m. Staff F, Registered Nurse (RN) stated that she did not know Resident #1 very well but was aware of his cough, had provided his nasal spray but was unaware that he had a weight gain. A document titled Weight Summary for Resident #1 revealed: a. On 1/18/24 admit weight measured at 266 pounds (lbs). b. On 3/20/24 weight measured 284.4 lbs. A hospital document titled Discharge Note dated 5/8/24 for Resident #1 revealed: a. Diagnosis Acute hypoxemic (lack of oxygen) respiratory failure. b. New onset Congestive Heart Failure (CHF). (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	A document provided by facility titled Staff Interview dated 5/13/24 signed by Staff B, CNA, revealed that she was aware 2 days prior to Resident #1's admission to the hospital that the resident did not want to get out of bed, his breathing was labored and she had reported it but was not sure to whom. A Policy titled Weight Assessment and Intervention dated 2008 revealed: a. The nursing staff will measure resident weights on admission and weekly for four weeks thereafter. b. Any weight change of 5% or more since the last weight assessment will be retaken as soon as possible for confirmation. If the weight is verified, nursing will notify the Dietitian. c. The Dietitian will respond and make recommendations as necessary. d. Care planning for weight loss or impaired nutrition will be a multidisciplinary effort and will include the Physician, nursing staff, the Dietitian, the Consultant Pharmacist, and the resident or resident's legal surrogate. A Policy titled Acute Clinical Changes dated 2018 directed staff as follows: a. The physician will help identify individuals with a significant risk for having acute changes of condition during their stay. b. In addition, the nurse shall assess and document/report the following baseline information: Vital signs and Neurological status. c. Before contacting a physician about someone with an acute change of condition, the nursing staff will collect pertinent details to report to the physician; d. The nursing staff will contact the physician based on the urgency of the situation. For emergencies, they will call or page the physician and request a prompt response (within approximately one-half hour or less). e. The nurse and physician will discuss and evaluate the situation. f. As needed, the physician will discuss with the staff and resident/patient and/or family the pros and cons of diagnosing and managing the situation in the facility or the need for hospitalization . During an interview on 5/14/24 at 2:10 p.m. The Corporate Nurse stated the facility was made aware of the daughters concern from the hospital Social Services note, initiated an investigation and provided education for the nursing staff on 5/10/24 to include the need for weights to be documented in Point Click Care, if an increase in edema is noted, report to the charge nurse immediately. She stated then the charge nurse would complete a head to toe and call the provider for further instructions and complete a Change of Condition Evaluation. She stated the nurses are to notify the provider of weight when assessing a resident for fluid retention.