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	02/03/2025

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46875 Based on clinical record review, staff interviews, and policy review the facility failed to notify the Physician and family when a resident experienced a change in condition for 1 of 3 residents reviewed (Residents #1). The facility reported a census of 75 residents. Findings include: The Clinical Census revealed Resident #1 was admitted to the facility on [DATE] and discharged from the facility on 1/27/25. Resident #1 did not have a Minimum Data Set (MDS) completed due to new admission to the facility. A Progress Note titled BIMS evaluation (Brief Interview for Mental Status) dated 1/24/25 identified a score of 8, which indicated moderately impaired cognition. Review of the Clinical Record revealed Resident #1 had diagnoses of delirium, altered mental status, muscle weakness, anxiety disorder, pleural effusion, acute kidney failure, asthma, atrial fibrillation and a stroke affecting the left side. Review of Bowel Elimination form for Resident #1 revealed two large loose/diarrhea stools on 1/25/25 and three large loose/diarrhea stools on 1/26/25. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/29/25 at 1:19 PM, Staff E, Certified Nursing Assistant (CNA) stated she had gotten Resident #1 up for breakfast on Saturday, 1/25/25. She said after breakfast, Resident #1 was sliding out of her wheelchair and Staff A, Registered Nurse (RN) told her to lay Resident #1 down. She said Staff F, CNA helped her get Resident #1 into bed around 9:30-10:00 AM. Staff E said when they went to change Resident #1 she started vomiting yellow stomach bile. She stated she vomited quite a bit because it was all over her, on the bed and on the floor. She stated her 1st bowel movement (BM) was formed and then after the BM became more liquid. She stated the rest of the day she was changing Resident #1 every 1-2 hours due to diarrhea. She stated Resident #1 did not throw up again until between 1:00-3:00 PM. She said family was visiting and she started spitting up a small amount. Staff E reported she told Staff A, RN all day long that Resident #1 was sick and had diarrhea. She stated she did not know if Staff A did anything about it. Staff E reported she did what she was supposed to do and reported it to the nurse. Staff E said she told Staff A every time she went in the room and changed her. She stated she told Staff A, something was not right with Resident #1. She said Resident #1 was not good on Saturday. She reported she usually will watch to see if the nurse goes in the room but she was so busy she does not know what the nurse did. On 1/29/25 at 3:39 PM, Staff F, CNA reported she was walking down the 100 hallway and Staff E, CNA asked for help. She reported Staff E had told her that Resident #1 had BM up her back and needed help changing her. Staff F reported they started changing Resident #1 and she started throwing up yellow bile. She stated the vomit got onto the bed and onto Resident #1. She stated she did not see it get on the floor. She reported Resident #1 was throwing up, gagging and pooping all at the same time. She said the BM started off hard and then got soft and there was a lot of stool. Staff F reported Staff E left the room a couple of times to get blankets and a mask. She stated she was gone probably 5-10 minutes so she assumed she had told the nurse as she was gone quite awhile. She stated they had to change Resident #1's bedding and get her into the nightgown. She stated after they got her pulled up in bed, she left the room. She reported she told the nurse, Staff A twice that Resident #1 was throwing up and pooping at the same time. On 1/29/25 at 4:53 PM, Staff A, RN reported her observations on Saturday, 1/25/25 revealed Resident #1 was at baseline. When asked if any staff members reported vomiting or diarrhea to her on Saturday, Staff A said she did not remember anyone telling her anything about vomiting or loose stools. She stated she was going off memory and did not recall. She said she can't say they didn't. She said, Maybe they did tell me and I forgot or didn't remember to follow up. Review of the clinical record lacked any assessments and interventions related to the nausea, vomiting and diarrhea on 1/25/25. There was no family or Physician notification documented in the progress notes regarding the nausea, vomiting or diarrhea on 1/25/25. A facility policy titled Change in Resident's Condition or Status revised February 2021 documented the facility promptly notified the resident, his or her attending physician, and the resident representative of changes in the resident's medical/mental condition and/or status. The policy further documented prior to notifying the Physician or healthcare provider, the nurse will make detailed observations and gather relevant and pertinent information for the provider, including information prompted by the Interact SBAR Communication form.

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 46875 Based on clinical record review, staff interview, facility investigation review and policy review the facility failed to report an allegation of abuse within 2 hours to the Iowa Department of Inspections, Appeals and Licensing (DIAL) for 2 of 3 residents reviewed (Residents #2 and #3). The facility reported a census of 75 residents. Findings include: An Incident Report (IR) dated 1/8/25 at 3:30 PM documented Resident #2 was arguing with Resident #3 over who was going to marry the medication aide in that hallway. When the staff member entered the room, she observed Resident #2 standing over the bed of Resident #3 and Resident #3 reported Resident #2 had hit him on his right arm. Resident #2 confessed to hitting Resident #3. The report documented that both residents were separated. Review of document titled Intake Information revealed the facility filed an allegation for abuse related to a Resident to Resident Altercation for Resident #2 and Resident #3 on 1/9/25 at 12:06 AM. On 2/3/25 at 8:59 AM, the Administrator acknowledged and verified the incident occurred on 1/8/25 at 3:30 PM and the self report was filed with DIAL on 1/9/25 at 12:06 AM. The Administrator reported she thought she had 24 hours to report unless there was an injury. The Administrator reported she must have interpreted the rules incorrectly. The facility policy titled Abuse, Neglect, Exploitation and Misappropriation Prevention Program revised April 2021 documented residents have the right to be free from abuse, neglect, misappropriation of resident property and exploitation. The policy further directed staff to investigate and report any allegation within timeframes required by federal requirements.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46875 Based on clinical record review, staff interviews and policy review the facility failed to provide care and services according to accepted standards of clinical practice for 1 of 3 residents reviewed (Residents #2). The facility failed to implement physician orders in a timely manner. The facility reported a census of 75 residents. Findings include: Resident #2's Quarterly Minimum Data Set (MDS) dated [DATE] identified a Brief Interview for Mental Status (BIMS) score of 14, which indicated intact cognition. The MDS included diagnoses of hypertension (high blood pressure), diabetes mellitus, and hyperlipidemia. An Email Correspondence received by the DON (Director of Nursing) from the facility Advanced Registered Nurse Practitioner (ARNP) on 1/14/25 at 7:05 PM documented the following new Physician orders for Resident #1: -Increase Jardiance (diabetic medication) from 10 MG (milligrams) to 25 MG daily -Increase Insulin Glargine bedtime dose to 28 units subcutaneous -Start Cimetidine (medication used to decrease libido) 300 MG every HS (hour of sleep) for sexual inhibition -Start Citalopram (antidepressant) 20 MG daily for depression and anxiety - Give Lasix (diuretic) 20 MG daily for 4 days related to fluid overload Review of Resident #2's Progress Notes lacked documentation of the new Physician orders being received by the facility. Review of the January 2025 Medication Administration Record (MAR) revealed there was a delay in implementing the new physician orders from 1/14/25: -Jardiance 25 MG daily- started on 1/18/25 -Insulin Glargine 28 units subcutaneous at bed time- started on 1/17/25 -Cimetidine 300 MG every HS- started on 1/18/25 -Citalopram 20 MG daily- started 1/19/25 - Lasix 20 MG daily for 4 days- administered from 1/18 to 1/21/25. On 2/3/25 at 12:15 PM, The Director of Nursing (DON) reported she sent the nurses a screenshot of the new orders on 1/15/25. She reported she expected the nurses to implement the orders as directed. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/3/25 at 12:54 PM, the DON and Nurse Consultant acknowledged and verified there was delay in implementing the physician orders. The DON reported she should have implemented the new physician orders immediately on the evening of 1/14/25 when the orders were received. A facility policy titled Medication and Treatment Orders revised July 2016 documented orders for medications and treatments will be consistent with principles of safe and effective order writing. The policy further documented verbal orders must be recorded immediately in the resident's electronic medical record by the person receiving the order.

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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 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** 46875 Based on clinical record review, staff interviews, and policy review the facility failed to provide assessment and interventions necessary for the care and services, to maintain the residents' highest practical physical well- being for 2 of 3 residents reviewed (Resident #1 and #2). The facility failed to complete and document nursing assessments related to nausea, vomiting and diarrhea for Resident #1. The facility also failed to complete vital signs with neurological assessments and complete a range of motion (ROM) assessment after a fall for Resident #1. The facility also failed to complete and document nursing assessments related diuretic usage for fluid overload and assess/monitor the efficacy and side effects of new medications started for fluid overload, sexual inhibition, anxiety and depression for Resident #2. The facility reported a census of 35 residents. Findings include: 1. The Clinical Census revealed Resident #1 was admitted to the facility on [DATE] and discharged from the facility on 1/27/25. Resident #1 did not have a Minimum Data Set (MDS) completed due to new admission to the facility. A Progress Note titled BIMS evaluation (Brief Interview for Mental Status) dated 1/24/25 identified a score of 8, which indicated moderately impaired cognition. Review of the Clinical Record revealed Resident #1 had diagnoses of delirium, altered mental status, muscle weakness, anxiety disorder, pleural effusion, acute kidney failure, asthma, atrial fibrillation and a stroke affecting the left side. Review of Bowel Elimination form for Resident #1 revealed two large loose/diarrhea stools on 1/25/25 and three large loose/diarrhea stools on 1/26/25. A Progress note dated 1/25/25 at 5:56 PM (late entry) titled Skilled evaluation documented Resident #1 was alert and confused with no signs or symptoms of discomfort, shortness of breath or chest pain. Resident #1's vital signs were stable. The note documented Resident #1's mucus membranes were dry and staff encouraged to offer a variety of fluids. Resident #1 in the room most of the day and was up for meals with supervision. Resident #1 only took a couple of bits and refused rest of food during meals. Bowel sounds active in all quadrants. No concerns voiced. Review of the Progress note details revealed the note was created on 1/28/25 at 1:11 PM, almost 72 hours later. An Incident Report (IR) dated 1/26/25 at 10:00 AM documented an unwitnessed fall in Resident #1's room. The IR revealed the nurse walked by Resident #1's room and found Resident #1 on the floor behind the bed, sitting on her buttocks, facing the dresser and yelling for help. The note documented Resident #1 had gripper socks on. Resident #1 said, I want to get to the bathroom. The IR documented the nurses assessed Resident #1's skin with no injuries noted and range of motion (ROM) was within normal limits. The IR revealed three Certified Nursing Assistants (CNA) helped Resident #1 into the wheelchair, provided cares and then assisted Resident #1 back to bed. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Neurological Evaluation directed staff to complete neurological assessments and vital signs at the following increments: initial, 15 minute checks x 4, 30 minute checks x 2, 1 hour checks x2, and 8 hour checks x 9. The Neurological Evaluation dated 1/26/25 revealed the initial neurological assessment at 10:00 AM for Resident #1 was partially completed and lacked a set of vital signs. The evaluation documented Resident #1 vitals signs were completed and findings were to be entered into the weights/vital tab in the clinical record. Review of the weight/vital tab lacked vital sign information for Resident #1 at 10:00 AM. Review of the Neurological Evaluation dated 1/26/25 revealed the remainder of the neurological assessments after 10:00 AM documented Resident #1 vitals signs were completed and findings were to be entered in the weight/vital tab of the medical record. The neurological evaluation lacked the date and time the vitals signs and neurological assessments were completed. Review of the weight/vital tab lacked any vital sign information on 1/26/25 until 6:00 PM. An IR dated 1/26/25 at 5:00 PM documented an un-witnessed fall in Resident #1's room. The IR revealed the nurse was called into Resident #1's room due to Resident #1 being on the floor. The IR documented Resident #1 was laying on the floor facing the ceiling, yelling for help. Resident #1 was incontinent of BM (bowel movement) and had gripper socks on. The IR documented the nurse assessed resident skin with no skin issue noted and no signs or symptoms of pain. The IR documented two CNAs helped Resident #1 from the floor into her wheelchair and provided cares. Resident #1 was then taken out of her room to the nurse's station. The IR lacked documentation that a ROM assessment was completed on Resident #1's upper and lower extremities. On 1/28/25 at 12:20 PM, Resident #1's daughter reported she had come to the facility with her sister Saturday morning (1/25/25) and when she walked into the room it was a mess. She said there were sheets and blankets piled up on the two chairs in the room. There was a cup on the floor that looked like her mom had vomited in it and was spilled on the carpet. She said her mom was lying on the mattress with no sheets, no nothing. She said there were clothes on the floor with yellow vomit on them. She said she went to pick the clothes up to mark them with a fabric marker before the clothes went to the laundry and it looked like the vomit had been sitting on the clothes for awhile. Resident #1's daughter said the aide reported to her that nobody gave the staff information on how to care for her mom. She stated there were no paper towels or towels in the bathroom. Resident #1's daughter reported she returned to the facility on Sunday and the Activity Director came into the room to ask some questions. She said the Activity Director started asking her mom questions and then her mom started pointing at her mouth as she was going to throw up. She stated the Activity Director wanted to get the bed up so her mom did not aspirate. She stated once the Activity Director got the head of the bed up her mom started heaving yellow bile. She stated the bathroom still did not have any paper towels or towels and that the aide had tried to give her mom toilet paper which incinerated. She stated they had to use a blanket and could not catch all the vomit. She stated her mom had vomit all over herself, basically the whole top of her body. She stated the Activity Director got staff to help clean up her mom. Resident #1's daughter reported she had to leave for an appointment at noon and returned to the facility around 4:00 PM. She reported when she entered her mom's room and the room stunk of bowel movement (BM). She stated her mom told her she had pooped. She reported you could smell the BM in the hallway. She stated her mom was lying in diarrhea. She reported she did not know how long she had been lying in it. She stated Staff D, CNA came in and helped clean up her mom. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/29/25 at 1:19 PM, Staff E, Certified Nursing Assistant (CNA) stated she had gotten Resident #1 up for breakfast on Saturday, 1/25/25. She stated after breakfast, Resident #1 was sliding out of her wheelchair and Staff A, RN (Registered Nurse) told her to lay Resident #1 down. She said Staff F, CNA helped her get Resident #1 into bed around 9:30-10:00 AM. Staff E said when they went to change Resident #1 she started vomiting yellow stomach bile. She stated she vomited quite a bit because it was all over her, on the bed and on the floor. She stated her 1st BM was formed and then after the BM became more liquid. She stated the rest of the day she was changing Resident #1 every 1-2 hours due to diarrhea. She stated Resident #1 did not throw up again until between 1:00-3:00 PM. She said Resident #1's family was visiting and she started spitting up small amounts. Staff E reported she told Staff A, RN all day long that Resident #1 was sick and had diarrhea. She stated she did not know if Staff A did anything about it. Staff E reported she did what she was supposed to do and reported it to the nurse. Staff E said she told Staff A every time she went in the room and changed her. She stated she told Staff A, something was not right with Resident #1. She said Resident #1 was not good on Saturday. She reported she usually will watch to see if the nurse goes in the room but she was so busy she does not know what the nurse did. On 1/29/25 at 3:39 PM, Staff F, CNA reported she was walking down the 100 hallway and Staff E, CNA asked for help. She reported Staff E had told her that Resident #1 had BM up her back and needed help changing her. Staff reported they started changing Resident #1 and she started throwing up yellow bile. She stated the vomit got onto the bed and onto Resident #1. She stated she did not see it get on the floor. She reported Resident #1 was throwing up, gagging and pooping all at the same time. She said the BM started off hard and then got soft and there was a lot of stool. Staff F reported Staff E left the room a couple of times to get blankets and a mask. She stated she was gone probably 5-10 minutes so she assumed she had told the nurse as she was gone quite awhile. She stated they had to change Resident #1's bedding and get her into the nightgown. She stated after they got her pulled up in bed, she left the room. She reported she told the nurse, Staff A, RN twice that Resident #1 was throwing up and pooping at the same time. On 1/29/25 at 4:53 PM, Staff A, RN reported her observations on Saturday, 1/25/25 revealed Resident #1 was at baseline. When asked if any staff members reported vomiting or diarrhea to her on Saturday, Staff A said she did not remember anyone telling her anything about vomiting or loose stools. She stated she was going off memory and does not recall. She said she can't say they didn't. She said, Maybe they did tell me and I forgot or didn't remember to follow up. Review of the Progress Notes on 1/25/25 revealed no other nursing assessments except for a BIMS assessment on 1/25/25 at 8:45 AM and a late entry for a SNF assessment that was documented on 1/28/25 for 1/25/25. The clinical record lacked any assessments and interventions related to the nausea, vomiting and diarrhea on 1/25/25. There was no family or Physician notification documented in the progress notes regarding the nausea, vomiting or diarrhea on 1/25/25. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/30/25 at 8:20 AM, The Director of Nursing (DON) verified and acknowledged there had been no assessments completed or documented in the progress notes from 1/25/25 related to the nausea, vomiting and diarrhea for Resident #1. The DON reported she had followed up and talked to Staff E, CNA and Staff F, CNA. She said Staff E reported Resident #1 had an emesis on Saturday morning and Staff F had helped her clean it up. She reported Staff E told her that Resident #1 had frequent bowel movements on Saturday and that another resident kept pushing her call lights as the resident was concerned about Resident #1. The DON reported Staff E told her she had told Staff A, RN 2-3 times about the vomiting and stools. The DON reported Staff E did not put the concerns in the clinical alerts. The DON reported the clinical alerts would show documentation that the CNA reported the concerns, help the nurse remember and keep the nurse accountable. The DON reported Staff F assisted Staff E with cleaning up Resident #1. She said Staff F reported she walked up to Staff A, RN and told her Resident #1 was puking and having a BM at the same time. The DON reported she followed up with Staff A, RN and Staff A reported she did not remember anyone coming up to her. The DON reported Staff A completed the SNF assessment on Saturday and had her vitals written on a piece of paper. The DON acknowledged Staff A documented the SNF assessment in the computer on Tuesday. The DON reported she would expect the Provider and family to be notified of the nausea, vomiting, and diarrhea and also if it was a recurring issue. She stated the staff should be aware of BM's daily. The DON said if the resident was having more than one of the three (nausea, vomiting or diarrhea) she would expect the Provider to be notified or a combination of all three then the Provider should be notified to get new orders. When asked about Resident #1 symptoms on Saturday, she stated she would have expected the Provider to be notified along with assessments and documentation in the progress notes. The DON acknowledged after Resident #1's first fall on 1/26/25 the medical record lacked documentation of vital signs with the neurological assessments and lacked dates/times the assessments were completed. The DON stated she would expect vital signs and a neurological assessment to be completed after an unwitnessed fall. The DON reported she would expect the neurological assessments along with vital signs to be completed according to the facility policy. When asked about frequency of the assessments, she reported she would expect the nurses to complete the neurological assessments and vital signs according to time frames that are listed in the electronic medical record or the paper form. When asked DON about Resident #1's second fall, she verified and acknowledged the fall assessment did not include documentation regarding a ROM assessment. The DON reported she would expect the staff to follow the fall policy and complete a thorough assessment. A facility policy titled Change in Resident's Condition or Status revised February 2021 documented the facility promptly notified the resident, his or her attending physician, and the resident representative of changes in the resident's medical/mental condition and/or status. The policy further documented prior to notifying the Physician or healthcare provider, the nurse will make detailed observations and gather relevant and pertinent information for the provider, including information prompted by the Interact SBAR Communication form. 2. The Quarterly MDS assessment for Resident #2 dated 11/6/24 identified a BIMS score of 14, which indicated intact cognition. The MDS included diagnoses of hypertension (high blood pressure), diabetes mellitus, and hyperlipidemia. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Care Plan target date 4/28/25 documented Resident #2 had displayed intimate behavior with a female resident and had exhibited physical aggression towards another resident. The Care Plan directed staff to administer medications as ordered. The Care Plan directed staff to anticipate a possible weight gain related to improvement in intakes compared to prior admit and enjoyment of food. The Care Plan directed staff to obtain weight per orders and/or facility policy and to use the same scale month to month as possible. Resident #2's weight summary documented the following weights: 11/3/24- 192.6 lbs (pounds) 12/6/24- 196.4 lbs 1/8/25- 204.0 lbs An Incident Report (IR) dated 1/8/25 at 3:30 PM documented Resident #2 was arguing with his roommate over who was going to marry the medication aide in that hallway. When staff member entered the room, she observed Resident #2 standing over the bed of his roommate and his roommate was saying that Resident #2 had hit him on his right arm. Resident #2 confessed to hitting the roommate. Both residents were separated. An Email Correspondence received by the Director of Nursing (DON) from the facility ARNP (Advanced Registered Nurse Practitioner) on 1/14/25 at 7:05 PM documented the following new Physician orders for Resident #1: -Increase Jardiance (diabetic medication) from 10 milligrams (MG) to 25 MG daily -Increase Insulin Glargine bedtime dose to 28 units subcutaneous -Start Cimetidine (can be used to decrease libido) 300 MG every hour of sleep (HS) for sexual inhibition -Start Citalopram (antidepressant) 20 MG daily for depression and anxiety - Give Lasix (diuretic) 20 MG daily for 4 days related to fluid overload Review of the January 2025 Medication Administration Record (MAR) revealed there was a delay in implementing the new physician orders from 1/14/25: -Jardiance 25 MG daily- started on 1/18/25 -Insulin Glargine 28 units subcutaneous at bed time- started on 1/17/25 -Cimetidine 300 MG every HS- started on 1/18/25 -Citalopram 20 MG daily- started 1/19/25 - Lasix 20 MG daily for 4 days- administered from 1/18 to 1/21/25. (continued on next page)

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Parkridge Specialty Care	5800 NE 12th Avenue Pleasant Hill, IA 50327

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #2's Progress Notes lacked documentation of the new Physician orders being received by the facility. The Progress Notes lacked documentation and completion of nursing assessments related to fluid overload and the start of a diuretic medication. The Progress Notes also lacked documentation of assessments and monitoring for the efficacy and side effects of the new or increased medications. On 2/3/25 at 12:15 PM, The DON reported she sent the nurses a screenshot of the new orders on 1/15/25. She reported she expected the nurses to implement the orders as directed. The DON reported when starting a diuretic medication she would expect fluid volume assessments completed and documented in the progress notes. On 2/3/25 at 1:49 PM, the DON reported she followed up with the facility Advanced Registered Nurse Practitioner (ARNP) regarding the order for Lasix. The DON reported the ARNP reported she had done a chart review on Resident #1 due to the incident on 1/8/25. The DON reported the ARNP ordered the Lasix related to weight gain of 12 lbs in the past 2 months and increased edema to Bilateral lower extremities (BLE). The DON reported Resident #2 current weight as of 2/3/25 was 199 lbs. The DON acknowledged there were no assessments regarding the weight gain on 1/8/25.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 46875 Based on clinical record review, staff interviews, family interviews, hospital record review and policy review the facility failed to provide adequate nursing supervision to prevent accidents and injuries for 1 of 3 residents reviewed (Resident #1) for falls. Resident #1 was identified as a fall risk prior and upon admission and interventions to prevent falls were not implemented upon admission to the facility. Resident #1 fell two times on the same day within 48 hours of admission. Based on staff interviews and documentation the staff did not provide appropriate level of assistance with transfers and the facility failed to complete a thorough assessment including vital signs and range of motion (ROM) after a fall occurred. The facility reported a census of 75 residents. Findings include: The Clinical Census revealed Resident #1 was admitted to the facility on [DATE] and discharged from the facility on 1/27/25. Resident #1 did not have a Minimum Data Set (MDS) completed due to new admission to the facility. Review of Hospital Physical Therapy (PT) notes dated 1/22/25 revealed Resident #1 was a fall risk and had a bed alarm. The note documented that PT recommended assistance of 2 persons with a gait belt and mechanical stand for transfers. A Progress Note titled BIMS evaluation (Brief Interview for Mental Status) for Resident #1 dated 1/24/25 identified a score of 8, indicating moderately impaired cognition. Review of the Clinical Record revealed Resident #1 had diagnoses of delirium, altered mental status, muscle weakness, anxiety disorder and a stroke affecting the left side. A Fall Risk assessment dated [DATE] identified Resident #1 scored an 8. The form documented a total score of 10 or above represents a high risk for falls. The Care Plan Conference Evaluation dated 1/24/25 at 5:00 PM documented Resident #1 was a fall risk. Review of the Initial Care Plan dated 1/24/25 did not address Resident #1 was a fall risk and lacked documentation of fall interventions. The Initial Care Plan titled Activities of Daily Living dated 1/24/25 directed staff to use a mechanical stand and assistance of 2 persons with transfers. The Initial Care Plan dated 1/25/25 revealed Resident #1 had impaired cognitive function/ dementia related to CVA (cerebrovascular accident/stroke), mild cognitive impairment and delirium. Resident #1's Kardex with admitted [DATE] directed staff to use a mechanical stand and assistance of 2 persons with transfers. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An Incident Report (IR) dated 1/26/25 at 10:00 AM documented an unwitnessed fall in Resident #1's room. The IR revealed the nurse walked by Resident #1's room and found Resident #1 on the floor behind the bed, sitting on her buttocks, facing the dresser and yelling for help. The note documented Resident #1 had gripper socks on. Resident #1 said, I want to get to the bathroom. The IR documented the nurses assessed Resident #1's skin with no injuries noted and range of motion (ROM) was within normal limits. The IR revealed three Certified Nursing Assistants (CNA) helped Resident #1 into the wheelchair, provided cares and then assisted Resident #1 back to bed. Review of the IR revealed a mechanical lift or stand was not utilized to transfer the resident per the Care Plan. The Neurological Evaluation directed staff to complete neurological assessments and vital signs at the following increments: initial, 15 minute checks x 4, 30 minute checks x 2, 1 hour checks x2, and 8 hour checks x 9. The Neurological Evaluation dated 1/26/25 revealed the initial neurological assessment at 10:00 AM for Resident #1 was partially completed and lacked a set of vital signs. The evaluation documented Resident #1 vitals signs were completed and findings were to be entered into the weights/vital tab in the clinical record. Review of the weight/vital tab lacked vital sign information for Resident #1 at 10:00 AM. Review of the Neurological Evaluation dated 1/26/25 revealed the remainder of the neurological assessments after 10:00 AM documented Resident #1 vitals signs were completed and findings were to be entered in the weight/vital tab of the medical record. The neurological evaluation lacked the date and time the vitals signs and neurological assessments were completed. Review of the weight/vital tab lacked any vital sign information on 1/26/25 until 6:00 PM. An IR dated 1/26/25 at 5:00 PM documented an un-witnessed fall in Resident #1's room. The IR revealed the nurse was called into Resident #1's room due to Resident #1 being on the floor. The IR documented Resident #1 was laying on the floor facing the ceiling, yelling for help. Resident #1 was incontinent of bowel movement (BM) and had gripper socks on. The IR documented the nurse assessed resident skin with no skin issue noted and no signs or symptoms of pain. The IR documented two CNAs helped Resident #1 from the floor into her wheelchair and provided cares. Resident #1 was then taken out of her room to the nurse's station. The IR lacked documentation that a ROM assessment was completed on Resident #1's upper and lower extremities. Review of the IR revealed a mechanical lift or stand was not utilized to transfer the resident per the care plan. A Progress Note titled Incident, Accident, Unusual Occurrence dated 1/26/25 at 5:56 PM (Late Entry) documented the nurse was called into Resident #1's room due to Resident #1 being on the floor. The note documented Resident #1 was laying on the floor facing the ceiling, yelling for help. Resident #1 was incontinent of BM and had gripper socks on. The note documented that the nurse assessed Resident #1's skin with no skin issue noted and no signs or symptoms of pain. The note documented two CNAs helped Resident #1 from the floor into her wheelchair and provided cares. Resident #1 was then taken out of her room to the nurse's station. The note lacked documentation that a ROM assessment was completed on Resident #1's upper and lower extremities. Review of the note revealed a mechanical lift or stand was not utilized to transfer the resident per the Care Plan. Review of the progress note revealed the note was not created until the following day on 1/27/25 at 2:58 PM. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Progress Note dated 1/26/25 at 6:53 PM revealed staff administered Lorazepam (antianxiety medication) 1 milligram (MG) for crying, yelling and restlessness. A Progress Note dated 1/26/25 at 12:30 AM revealed staff administered Acetaminophen (pain medication) 325 MG 2 tablets. A Progress Note dated 1/27/25 at 3:18 AM revealed staff administered Lorazepam 1 MG for crying, yelling and restlessness. A Progress Note dated 1/27/25 at 3:41 AM documented the administration of the Lorazepam was ineffective. A Progress Note titled dated 1/27/25 at 4:00 AM documented a change in condition related to altered mental status, falls, and Resident #1 seems different than usual. The note documented nursing observations and evaluation revealed Resident #1 had an altered mental status to where Resident #1 was not able to follow simple commands, Resident #1 had 2 falls on 1/26/25, and nursing was unable to complete an assessment due to Resident #1 swinging arms/legs all over and Resident #1 yelling out. The Primary Care Provider responded to the condition change form and directed staff to send Resident #1 to the emergency room . The Hospital emergency room Report dated 1/27/25 at 5:15 AM documented Resident #1 presented with altered mental status, increased falls and hypoxia (low oxygen). The note documented the clinical impression was acute on chronic respiratory failure, acute kidney injury and sepsis (life threatening blood infection) with acute renal failure without septic shock due to unspecified organism. The note documented Resident #1 would be admitted to the intensive care unit (ICU). Review of the Initial Care Plan revealed on 1/27/25 a Care Plan was developed related to falls. The focus of the Care Plan documented Resident #1 was at risk for falls. The fall interventions with a date initiated 1/27/25 included the following: -Anticipate and meet Resident #1 needs. -Assist Resident #1 with stand-by assistance for all ambulation. -Be sure the call light light is within reach and encourage Resident #1 to use it for assistance as needed. Resident #1 needs prompt response to all requests for assistance. -Call light reminder sign placed in Resident #1 room as a reminder to ask for assistance. -Medication review. A Computed Tomography (CT) Scan of the abdomen and pelvis without contrast dated 1/27/25 revealed a fracture of the left pubic bone medially. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Internal Medicine Resident ICU Progress Note dated 1/28/25 documented Resident #1 was more alert and reported her buttocks hurt. The note further documented Resident #1 was unable to answer orientation questions and remained in 4 point restraints. The note documented Resident #1 had a medial left pubic bone fracture that was noted on the CT scan of abdomen/pelvis from 1/27/25. The note documented the CT scan of the abdomen/pelvis from April 2024 made no mention of the pubic bone fracture. The note indicated uncertain chronicity and unknown if the fracture was related to the falls at the nursing home. The note directed a consult with orthopedics for management and weight-bearing recommendations. On 1/28/25 at 10:20 AM, Resident #1's son reported the facility was not prepared for his mom and his mom had deteriorated to the extreme while at the facility. He reported he was aware of at least 2 falls at the facility. He reported the facility did not have interventions in place to prevent his mom from falling out of bed or the wheelchair. He reported the facility came to the hospital and talked to his mom prior to admission and that the facility knew his mom was a fall risk. On 1/28/25 at 11:15 AM, Resident #1's son reported his mom had a fractured pelvic bone. He reported his mom had been in the hospital before coming to the nursing home and that there had been no signs of a fracture prior. Resident #1's son reported he felt the fracture occurred at the facility. On 1/28/25 at 12:20 PM, Resident #1's daughter reported she had been present in her mom's hospital room when two Physicians came into the room and asked her mom if she had any pain and she pointed to the pelvic area. Resident #1's daughter reported that one of the Physician's said that it made sense that her pain was there as she had a small pelvic fracture. Resident #1's daughter reported she asked the Physician if the fracture was due to the two falls her mom had and the Physician did not know for sure. Resident #1's daughter reported that her mom had been in the hospital from 12/6/24 until she went to the nursing home on 1/24/25. Resident #1's daughter reported she had visited Friday night and her mom's bed did not have any side rails on it which made her concerned and the bed was not in a low position. On 1/29/25 at 11:20 AM, the Administrator reported the immediate fall interventions are listed on the incident report and long term interventions are reviewed/discussed at the Interdisciplinary Team (IDT) meeting and then added to the Care Plan. The Director of Nursing (DON) reported on admission she had completed a fall risk assessment for Resident #1 and she scored an 8. The DON reported due to the score, fall risk was not triggered on the baseline/initial care plan. The DON verified and acknowledged Resident #1 had a telesitter in the hospital. The DON stated she had a telesitter due to her impulsive behaviors. She stated the telesitter had been discontinued for 24 hours. The Administrator and DON reported they were in the process of reviewing the falls on Monday, 1/27/25 when they received a phone call from the son. The DON reported the fall Care Plan was initiated on Monday and interventions added to the Care Plan. The Administrator reported Resident #1 came to the facility later Friday afternoon and went back to the hospital early Monday morning. The Administrator reported the IDT had not had a chance to review everything. The Administrator and DON reported they were not notified by the hospital a pelvic fracture was found. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/28/25 at 2:15 PM, Staff A, Registered Nurse (RN) reported on Sunday around 10:00 AM, Resident #1 had a fall from her bed. She stated she was in room [ROOM NUMBER] and saw Resident #1 on the floor yelling for help. She reported she got two aides, Staff B and Staff C to come to the room. She stated she assessed Resident #1 first before the aides got her up off the floor. She stated her assessment revealed no injuries, no bruising and no complaints of pain. She stated Staff B and Staff C got Resident #1 into the wheelchair, toileted her and then back into the wheelchair. She stated Resident #1 was not sitting great in the wheelchair so the aides got her back into bed. She stated a 3rd aide aide, Staff D who was assigned to Resident #1 also came into the room before Resident #1 got back into bed. She said Resident #1 required assistance of two with transfers and a gait belt. Staff A said she was present and watched the transfers as Resident #1 had a Foley catheter. Staff A reported when she had gone to room [ROOM NUMBER] prior to the fall she had seen Resident #1 was in bed and was positioned okay in the bed. She stated her bed was in a low position prior to the fall. She stated she did not see her fall out of the bed and that the fall was unwitnessed. Staff A stated Resident #1 was confused and unable to say if she hit her head or not. She reported she started neuro assessments after the fall. She stated neuro's are completed every 15 minutes for 1 hour, every 30 minutes for 1 hour, every hour for 2 hours, then every 8 hours for 3 days. She stated Resident #1's daughter came to the facility after the 1st fall and she told the daughter that her mom had fallen. Staff A reported the bed was in the lowest position and that the way the Resident #1 was positioned on the side of the bed, it looked like she had slid out of bed. She stated Resident #1 upper torso was still on the bed and her bottom was sitting on the floor. Staff A reported she had told the daughter she did not think Resident #1 had fallen hard and it looked like she had slid out. Staff A reported Resident #1 fell again on Sunday around 5:00 PM. She stated she was called in the room by Staff D. She said Resident #1 was behind the bed laying on her back, facing the ceiling and yelling for help. She stated both falls that occurred on Sunday happened behind the bed on the window side. Staff A reported she called for the aides, Staff B and Staff C again to help. Staff A stated she checked Resident #1 legs, skin and did not observe any injuries. She stated she did not see any signs of pain and that there was no grimacing or yelling with movement. Staff A reported Resident #1 was incontinent of soft BM (bowel movement) at the time of the fall and was in bed prior to the fall. Staff A reported she told Staff D to do more frequent checks on Resident #1. She said Staff D had gone to help a resident in another room and when she came back Resident #1 was on the floor. Staff A reported with the 1st fall she moved the call light to the side of the bed the fall had happened on and moved her bedside table closer. Staff A reported Resident #1 was very disoriented and she was trying to see what would work. When asked if Resident #1 used the call light and understood how it worked, she stated she had observed Resident #1 pushing the call light button and saying help. She reported after the 2nd fall she told Staff D to do more frequent checks. She said she did not specify an exact frequency of the checks but she wanted Staff D to pay more attention and go in the room as much as possible. She told Staff D that she could sit by the room to do documentation. She stated after the fall happened, she brought Resident #1 out to the nurses station. When asked about the frequency of the checks, she said she did not include a time frame as she did not want to say 15 minute checks or a 1:1 because if the facility was not able to do the checks then it would be not following an intervention. Staff A reported around 6:00 PM, Resident #1 was at the nurses station in her wheelchair and she had partially slid out. Staff A reported she was sitting at the nurses station and intervened. She stated Resident #1 did not fall out of her wheelchair. She reported she would have if she had not assisted her. She reported she did not treat it as a fall as the resident did not go from one surface to another. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/29/25 at 9:20 AM, Staff D, CNA reported when she got Resident #1 up out of bed for breakfast, she transferred Resident #1 by herself. She stated it was the first day working with her and she had asked the nurse how to transfer Resident #1. She stated she was told that she could use the mechanical stand with assistance of 2 or use 1 assist depending on her comfort level. Staff D stated she sat Resident #1 on the edge of the bed and pivoted her to the wheelchair using a gait belt. Staff D reported after breakfast Resident #1 stayed in her wheelchair while she went to check on another resident and when she returned she realized Resident #1 was not able to sit in her wheelchair well as she was leaning over. Staff D reported she assisted Resident #1 back into the bed by herself. Staff D stated when she was gone helping another resident was when Resident #1 had her first fall. She reported she thought the fall happened around 10:15 AM. She stated when she returned to the room Staff A was present. She said Resident #1 was sitting on the floor in an upward position with her head on the bed. She stated she was sitting on the side of the bed toward the window. Staff D reported Staff C and herself got Resident #1 off the floor. She stated there was one aide on each side of Resident #1 and they used her pants and under the arms to lift her up, sat her on the bed and then laid her down. Staff D reported they did not assist her to the toilet after the fall. Staff D stated Resident #1 was pretty weak and Staff C and herself supported Resident #1 during the transfer. Staff D reported they did not use a gait belt during the transfer. She stated they tried to put Resident #1 in the best position and then used an assist of 2 to transfer her. Staff D reported after the 1st fall she put a chair and charting desk in front of the door so she could keep an eye on her. She stated she noticed when Resident #1 was puking, she would lean over in the bed, reach with her hand for the corner of the bed, and pull herself off the bed. Staff D reported Resident #1 was puking a lot especially after she ate. Staff D reported Resident #1 had a second fall in her room around supper time. She stated she did not witness the fall. She reported prior to the fall Resident #1 was in bed. She stated Staff B waved her down to the room as she was getting a room tray. She said when she got to the room, she did not see the nurse in the room and was not sure if the nurse had been in the room before. Staff D reported Staff B and herself got Resident #1 up off the floor the same way she did after the 1st fall and got her back into the bed. Staff D reported she asked Staff A was she was supposed to do as Resident #1 needed someone to watch or redirect her and she had other residents to take care of. Staff D reported she was the only CNA assigned to the 100 hall. She reported Staff A told her to put Resident #1 in the wheelchair and to bring her out to the table at the nurses station. On 1/29/25 at 12:33 PM, Staff B, CNA reported around supper time Resident #1 had a fall. She stated she got Staff D, CNA and they picked Resident #1 up off the floor. Staff B reported Resident #1 was laying on her back by the window. She said her bed was in a low position. Staff B reported Resident #1 said she had rolled off the bed and wanted to get off the floor. She reported she did not see any signs of pain. She reported Staff A, RN had come into the room and had taken vitals and checked her over. Staff B reported she grabbed Resident #1's lower legs and Staff D grabbed her upper body and they picked her up and put her back into bed. When asked if they lifted her, she said yes. When asked if a gait belt was used, she said no. When asked what the CNAs used to direct them regarding a resident transfer status, she said the Kardex. When asked if she had reviewed Resident #1's Kardex, she said no because Resident #1 wanted to get up off the floor. Staff B reported on Saturday Resident #1 was sliding from the wheelchair in the common area and she helped reposition her. She said after the fall on Sunday, Resident #1 was incontinent of loose diarrhea. On 1/29/25 at 12:10 PM, Staff C, CNA reported she was aware Resident #1 had a couple of falls on Sunday but she did not recall helping get her up all the floor. She said Staff B and herself assisted Resident #1 with scooting up in bed after breakfast. (continued on next page)

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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/29/25 at 1:19 PM, Staff E, CNA reported Saturday morning (1/25/25) when she first got there, Resident #1 was laying sideways in bed and was screaming she had fallen out of bed. She said Resident #1 was confused. Staff E said she told Resident #1, she had not fallen and was still in bed. She stated she got Resident #1 up for breakfast. She stated after breakfast she was sliding out of her wheelchair and Staff A, RN told her to lay her down. She said Staff F, CNA helped her get Resident #1 into bed around 9:30-10AM. Staff E stated she asked the nurses about Resident #1's transfer status and nobody seemed to know. She said she also asked the speech therapist and the therapist did not know. She said you could tell Resident #1 had a stroke that affected her left side. Staff E stated the aides can get on the computer to look at the Kardex for the transfer status. She stated she did get on the computer that morning but did not see her name and at the same time was getting called to come down to her hall. She stated she used assist of 2 to transfer Resident #1 on Saturday. She said Staff F helped her transfer Resident #1 into bed but she did not remember who helped her transfer her into the chair. Staff E reported on Saturday she made sure her bed was all the way to the floor. She said she wanted the bed to be in the safest position in case she was to fall. She stated she kept checking on her and was constantly in the room. On 1/29/25 at 3:39 PM, Staff F, CMA reported the first time she saw Resident #1, she was sitting in the wheelchair by the nurses station and was not sitting up well. She said Staff A, RN had asked Staff E, CNA to lay Resident #1 down. She reported she was walking down the 100 hallway and Staff E asked for help as Resident #1 was incontinent of BM (bowel movement). She stated Resident #1 was already in bed. When asked if she had help transfer Resident #1 in bed, she stated she did not think she had helped lay her down. When asked if she had helped with any transfers on Saturday, she stated she did assist Staff E with a transfer before breakfast, getting Resident #1 in the wheelchair. She stated they did a two person transfer under the arms. When asked if they used a gaitbelt during the transfer, she said no. When asked if she had looked at the Kardex, she said no. She reported they could not find a gaitbelt and there was not one in the room. She said she knows they are supposed to use gaitbelts with transfers. Staff F verified and acknowledged she was not aware that Resident #1 was careplanned to be a mechanical stand with the assistance of 2 persons. On 1/29/25 at 2:48 PM, Staff G, RN reported she had sent Resident #1 to the hospital early Monday morning (1/27/25). She reported when she came to work on Sunday night at 6:00 PM She stated Resident #1 had just had diarrhea, had been given a shower and was being taken back to her room. She stated she was told Resident #1 had two falls, an unwitnessed fall and a witnessed fall out of her wheelchair. She stated no other issues were reported to her. She stated Resident #1 was restless and the dayshift Nurse did not know Resident #1 had an order for Lorazepam as needed. She stated she gave her the Lorazepam and it helped most of the night until the early morning. She said Resident #1 was restless again and she gave her another Lorazepam. She stated Resident #1 got more restless and was trying to throw herself out of the bed and would not let her obtain any vital signs. Staff G said she thought something was going on with Resident #1 as she was super restless and thought maybe the Lorazepam was having the opposite effect. She stated she called the on-call provider and received orders to send her to the emergency room . When asked about the fall out of the wheelchair, Staff G said she might have made a mistake about the fall from the wheelchair. She said when the ambulance came Resident #1's urine was dark brown and prior to that her urine had been yellow. She stated there was a major change in her restlessness and her urine. When asked about the Acetaminophen that was given at 12:30 AM on 1/27/25, she stated she thought Resident #1 might have been restless due to pain. She stated she gave the Acetaminophen and Resident #1 fell asleep for a little bit and then woke up restless again. Staff G stated she thought she had done a Pain Assessment in Advance Dementia (PAINAD) as Resident #1 was alert to self only and not able to verbalize what her pain score was. (continued on next page)

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	02/03/2025

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

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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/30/25 at 8:20 AM, The DON reported she had completed the admission for Resident #1 on Friday night around 4:45 PM. She stated it was a typical admission. She reported Resident #1 came to the facility fairly confused and she was not sure on her mentation baseline. The DON reported Resident #1's son had reported that Resident #1 was anxious during the night at the hospital and the hospital would use medications. The DON reported Resident #1 had some hospital delirium. She said Resident #1's son told her that his mom had her days and nights mixed up at the hospital and the medications helped her sleep during the night which helped improve her delirium. The DON reported Resident #1 had a telesitter at the hospital because the delirium was making her impulsive. She said the telesitter was discontinued at the hospital around 1/23/25. The DON reported she expected the staff to check the Kardex for the resident's transfer status and to follow the Kardex. The DON reported she expected gait belts to be used with every resident who required assistance with transfers. She stated if the Kardex directed staff to use a mechanical stand for a transfer and the resident was unsafe to use it then she would expect the staff to use the mechanical lift. She said on Friday when she got report from the hospital she was informed by the hospital that they were using a mechanical stand to transfer Resident #1. The DON said she continued with what the hospital was doing until therapy at the facility could evaluate Resident #1. The DON verified Resident #1 had not been seen by Physical or Occupational therapy at the facility. The DON reported resident's Kardexs are updated anytime something changes. The DON acknowledged after Resident #1's first fall the medical record lacked documentation of vital signs with the neurological assessments and lacked dates/times the assessments were completed. The DON stated she would expect vital signs and a neurological assessment to be completed after an unwitnessed fall. The DON reported she would expect the neurological assessments along with vitals to be completed according to the facility policy. When asked about frequency of the assessments, she reported she would expect the nurses to complete the neurological assessments and vital signs according to time frames that are listed in the electronic medical record or the paper form. When asked DON about Resident #1's second fall, she verified and acknowledged the fall assessment did not include documentation regarding a ROM assessment. The DON reported she would expect the staff to follow the fall policy and complete a thorough assessment. On 2/3/25 at 9:06 AM, Hospital Critical Care Internalist verified and acknowledged Resident #1's pubic fracture found in the CT scan. She said it was hard to know the time frame of when the fracture occurred. She reported she went back through the medical record and CT abdomen/pelvis in April 2024 made no mention of a public bone fracture. She said the fracture could have occurred anytime during that time frame April 2024 until now. She said she could not say with any certainty that the fracture was related to the falls at the facility. She said the sepsis was related to urinary tract infection and antibiotics had been adjusted. The facility policy titled Falls and Fall Risk, Managing revised March 2018 documented based on previous evaluations and current data, the staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falling. The facility policy titled Safe Lifting and Movement of Residents revised 2017 documented in order to protect the safety and wellbeing of staff and residents, and to promote quality of care, this facility uses appropriate techniques and devices to lift and move residents. The policy further documented that nursing staff, in conjunction with the rehabilitation staff, shall assess individual's residents' needs for transfer assistance on an ongoing basis. Staff will document resident transferring and lifting needs in the Care Plan.