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	07/03/2025

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on observations, clinical record review, resident and staff interview, facility policy review, the facility failed to follow the comprehensive Care Plan for 1 of 3 (Resident #2) reviewed for care plans. The facility reported a census of 84 residents. Findings include: The Quarterly Minimum Data Set (MDS) of Resident #2, dated 6/18/25, coded the resident dependent on assistance for personal hygiene, transfers and bed mobility. The MDS documented diagnoses that included diabetes mellitus, hemiplegia (muscle weakness or partial paralysis on one side of the body that can affect the arms legs, and facial muscles) and macular degeneration (damage to the eyes retina, causing loss of vision). The Care Plan of Resident #2, revision date 1/2/25, identified a focus area of the Resident will continue to participate during my activities of daily living (ADL) as my condition allows. The Care Plan directed the staff she required 2 staff to assist me with cares, and 2 assist with bed mobility and 2 assist with upper and lower body dressing. Observation on 6/25/25 at 11:40 a.m., with Resident #2, was lying in bed ready to get up for the noon meal. Staff C, Certified Nurse Aide (CNA) and Staff E, CNA assisted the resident to roll from side to side to position the Hoyer lift (mechanical lift) sling underneath her. Resident #2 protected her right upper arm as staff were rolling her. A Incident Accident Unusual Occurrence Note dated 4/29/25 at 3:00 p.m. documented as follows; It was brought to this nurse's attention that the resident complained that Staff E, CNA, was rough with her during the morning while assisting getting the resident up for the day and hurt her right arm. A Orders Administration Note dated 4/29/25 at 4:32 p.m. documented that Tramadol (opioid pain killer) 50 milligrams (mg) by mouth was given for residents complaint of right shoulder pain, for a scored pain level of 8 out of 10. A Orders Administration Note dated 4/29/25 at 5:40 p.m. documented that the resident reported a 6 out of 10 pain level. A Orders Administration Note dated 4/29/25 at 8:38 p.m. documented that the resident reported pain to the shoulder and Tramadol 50mgs was administered to the resident. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Orders Administration Note dated 4/29/25 at 9:08 p.m. documented that the resident reported she was comfortable, and did not have pain. On 6/25/25 at 2:00 p.m., Staff E, CNA, verified that she rolled Resident #2 by herself on 4/29/25, and that the plan of care instructed staff to have 2 staff for bed mobility and for upper body dressing. On 7/2/25 at 9:40 a.m., Resident #2, verified that 2 staff are to roll her over and reposition her, and the day of the incident, only 1 staff member came in to get her ready for the day. On 6/25/25 at 2:45 p.m., the DON verified that staff are to follow the resident plan of care. The facility policy titled Using the Care Plan revised 8/2006 instructed staff to use in developing the residents daily care routines and will be available to staff personnel who have responsibility for providing care or services to the resident.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interview and policy review, the facility failed to provide incontinence care appropriately to prevent cross contamination for 1 of 3 residents observed for incontinence care (Resident #3). The facility reported a census of 84 residents. Findings include: 1. The Quarterly Minimum Data Set (MDS) assessment dated [DATE] documented Resident #3 had short and long term memory problems, severely impaired for decision making abilities, required substantial to maximal staff assistance for all aspects of daily living and incontinent of bowel. The MDS revealed diagnosis of quadriplegia (a condition characterized by paralysis in all four limbs (arms and legs). The Care Plan of Resident #3, revision date 8/16/24, identified a focus area of the Resident not experience any skin conditions from incontinence. The Care Plan directed the staff to assist me with perineal cleansing as needed and observe my skin daily for irritation and redness. Observation on 6/25/25 at 11:15 a.m., Staff K, Certified Nursing Assistant (CNA) provided incontinence cares on Resident #3. Staff K, CNA did hand hygiene and put on gloves. She then pulled enough wipes out and put them on a barrier surface next to the resident. She proceeded to clean the buttock area wiping from front to back. Once she cleaned the back side she then proceeded to clean her front peri area wiping from front to back with the wipe. Staff K failed to cleanse the right and left hips. Interview on 6/25/225 at 11:40 a.m., Staff F, RN, verbalized staff are to cleanse the thigh areas while providing incontinent cares to residents. Review of the facility's Perineal Care policy dated 2/2018, directed staff to continue to wash the perineum moving from inside outward to the thighs, Rinse perineum thoroughly in same direction, using fresh water and a clean washcloth .

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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 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, resident and staff interviews, clinical record review and policy review the facility failed to provide interventions to prevent a deep tissue injury (a type of pressure injury that occurs when underlying soft tissue is damaged due to prolonged pressure, often over bony prominence.) from performing for 1 of 5 residents reviewed (Resident #8) and failed to apply treatment to a Moisture Associated Skin Damage (MASD) area on the coccyx (the final bone at the bottom of the spine) for which resulted in the area had gotten worse and the Advance Registered Nurse Practitioner (ARNP was notified 7 days later. (Resident #9). The facility identified a census of 84 residents. Findings include: Determining the Stage of Pressure Injury: Stage 1 Pressure Injury: Non-blanchable erythema of intact skin Intact skin with a localized area of non-blanchable erythema, which may appear differently in darkly pigmented skin. Presence of blanchable erythema or changes in sensation, temperature, or firmness may precede visual changes. Color changes do not include purple or maroon discoloration; these may indicate deep tissue pressure injury. Stage 2 Pressure Injury: Partial-thickness skin loss with exposed dermis Partial-thickness loss of skin with exposed dermis. The wound bed is viable, pink or red, moist, and may also present as an intact or ruptured serum-filled blister. Adipose (fat) is not visible and deeper tissues are not visible. Granulation tissue, slough and eschar are not present. These injuries commonly result from adverse microclimate and shear in the skin over the pelvis and shear in the heel. This stage should not be used to describe moisture associated skin damage (MASD) including incontinence associated dermatitis (IAD), intertriginous dermatitis (ITD), medical adhesive related skin injury (MARSI), or traumatic wounds (skin tears, burns, abrasions). Stage 3 Pressure Injury: Full-thickness skin loss Full-thickness loss of skin, in which adipose (fat) is visible in the ulcer and granulation tissue and epibole (rolled wound edges) are often present. Slough and/or eschar may be visible. The depth of tissue damage varies by anatomical location; areas of significant adiposity can develop deep wounds. Undermining and tunneling may occur. Fascia, muscle, tendon, ligament, cartilage and/or bone are not exposed. If slough or eschar obscures the extent of tissue loss this is an Unstageable Pressure Injury. Stage 4 Pressure Injury: Full-thickness skin and tissue loss Full-thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage or bone in the ulcer. Slough and/or eschar may be visible. Epibole (rolled edges), undermining and/or tunneling often occur. Depth varies by anatomical location. If slough or eschar obscures the extent of tissue loss this is an Unstageable Pressure Injury. Unstageable Pressure Injury: Obscured full-thickness skin and tissue loss Full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because it is obscured by slough or eschar. If slough or eschar is removed, a Stage 3 or Stage 4 pressure injury will be revealed. Stable eschar (i.e. dry, adherent, intact without erythema or fluctuance) on the heel or ischemic limb should not be softened or removed. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Deep Tissue Pressure Injury: Persistent non-blanchable deep red, maroon or purple discoloration Intact or non-intact skin with localized area of persistent non-blanchable deep red, maroon, purple discoloration or epidermal separation revealing a dark wound bed or blood filled blister. Pain and temperature change often precede skin color changes. Discoloration may appear differently in darkly pigmented skin. This injury results from intense and/or prolonged pressure and shear forces at the bone-muscle interface. The wound may evolve rapidly to reveal the actual extent of tissue injury, or may resolve without tissue loss. If necrotic tissue, subcutaneous tissue, granulation tissue, fascia, muscle or other underlying structures are visible, this indicates a full thickness pressure injury (Unstageable, Stage 3 or Stage 4). Do not use DTPI to describe vascular, traumatic, neuropathic, or dermatologic conditions. 1. The Significant Change in Status Minimum Data Set (MDS) dated [DATE] for Resident #8 reflected that the resident was able to make herself understood and able to understand others. The MDS identified the Brief Interview for Mental Status (BIMS) score of 9 for which indicated moderate impaired decision making. The MDS revealed the resident required substantial to maximal assistance for bed mobility, and transfers and totally dependent on putting on/off of footwear. The active diagnoses portion of the Electronic Health Record (EHR) of Resident #8 documented diagnoses of acute osteomyelitis (inflammation of bone caused by infection) of right ankle and foot, diabetes mellitus, heart failure, acquired absence of left great toe, cerebrovascular disease (a term for a group of conditions that impact the brains blood vessels and blood flow), anxiety and depression. The Comprehensive Care Plan of Resident #8, initiated 5/9/24, identified a Focus Area of an Activities of Daily Living (ADL) and will continue to participate during my ADL as my condition allows. The Care Plan directed staff that the resident required 1 staff assistance for bed mobility and I am stand by pivot, assisted with two staff, left lower extremity, heal weight bearing only with post op shoe for transfers. The Interact Transfer Form dated 4/14/25 at 2:51 p.m., documented resident transferred to hospital for left great toe amputation due to diabetic ulcer to left great toe. The Care Plan identified a Focus Area, initiated on 4/22/25, identifying the resident has an actual impairment to skin: left first toe, amputation/surgical incision-healed. The Wound Evaluation form dated 5/13/25 at 1:16 p.m., revealed first digit on left foot as resolved. The Wound Evaluation form dated 5/13/25 at 1:17 p.m , revealed deep tissue injury on left plantar foot, 6 hours old, in house acquired. Measurements of area =0.65 centimeters (cm) by length= 0.8 cm by width =1. 13 cm., intake blister, with additional care of cushion, foam mattress, foot cradle, heel suspension/protective device and turning/repositioning program. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	The Health Status Note dated 5/13/25 at 1:30 p.m., Late entry, Certified Wound Ostomy Continence Nurse (CWOCN) to resident's bedside for weekly Skin & Wound Evaluation of left great toe amputation site. Resident sitting up in bed, removed resident's socks and thoroughly assessed both feet. Surgical incision to left foot found to be healed. Intact Deep Tissue Injury identified just distal to this area, to the resident's left plantar foot. Emphasized to resident the need for her feet to not come in contact with footboard as this is causing pressure to the skin. CWOCN placed resident's bilateral feet in heel protector boots and provided resident with education regarding when to wear the boots, when they should be removed. One Way Slide to be placed in resident's bed in an attempt to prevent her from sliding down and her feet coming in contact with the footboard. CWOCN educated staff of importance of keeping resident boosted in bed and bottom of feet from coming in contact with footboard. The Care Plan with revision dated 6/25/25, revealed resident with actual impairment to skin with left plantar foot deep tissue injury, with initiated date of 5/1/25, interventions to float my heels while in bed, I have a cushion I use while in bed to keep my heels floated, on 5/14/25, I have a one-way slide (a repositioning aid designed to help individuals maintain a seated position and assist care givers in reposition them without forward slippage) while in bed to keep me from sliding down in bed, preventing my feet from pressing against the foot board and on 6/18/25, Encourage me to wear a heel-protector boot to my left foot as tolerated. The Health Status Note dated 5/16/25, with no time, documented the resident is seen today for acute onset of foot pain. The patient also reports ongoing foot pain, which is present at the time of the visit. History of amputation of left great toe, patient reports current pain in foot. The Wound Evaluation form dated 5/20/25 at 3:28 p.m., revealed deep tissue injury on left plantar foot, 7 days old, in house acquired. Measurements of 0.89 cm by 1.03 cm by 1.03 cm., intake blister, with additional care of customized shoe wear and heel suspension/protective device. The Wound Evaluation form dated 5/27/25 at 12:27 p.m., revealed deep tissue injury of left plantar foot, 14 days old, in house acquired. Measurements of 1.69 cm by 1.29 cm by 1.19 cm. intake blister, with additional care of heel suspension/protection device and turning/repositioning program, The Wound Evaluation form dated 6/3/25 at 1:03 p.m., revealed deep tissue injury of left plantar foot, 21 days old, in house acquired. Measurements of 2.49 cm by 2.53 cm by 1.42 cm by deepest point= 0.3 cm intake blister, with additional care of heel suspension/protection device and turning/repositioning program. Progress is deteriorating. The Wound Evaluation form dated 6/10/25 at 5:24 p.m., revealed deep tissue injury of left plantar foot, 1 month old, in house acquired. Measurements of 5.02 cm by 2.3 cm by 2.62 cm by deepest point= 0.2 cm intake blister, with serosanguineous exudate (a type of wound drainage that contains both blood and serous fluid (a clear yellowish fluid also know as blood serum) additional care of heel suspension/protection device. Observation on 6/30/25 at 10:00 a.m., Staff F, Registered Nurse (RN) proceeded to do wound care to Resident #8 left plantar foot. Staff E, removed the old dressing and blood was noted to be on the dressing. Staff E, proceeded to apply new dressing as ordered to the bottom of the left plantar foot. No cushion to the bottom of the foot board. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Interview on 7/1/25 at 2:30 p.m., Staff F, was not able to determine when the interventions were put into place with Resident #8 per the care plan. Staff F verified that the foot cradle needed to be on the foot of the bed and also the foot board needed to be padded and that a turning/repositioning program was implemented. Interview on 7/1/25 at 4:20 p.m., Staff G, Certified Medication Aide (CMA) verified that a turning and reposition program is that the resident is turned or repositioned every 2 hours and that she was not sure that the floor aides had the ability to get into the computer system to verify that a resident is on a turning/repositioning program and that if the floor staff did not know that, then not sure if the resident would be turned and repositioned. On 7/2/25 at 8:20 a.m., Resident #8 was lying in bed with a green boot on her left foot. The blue foot cradle pillow was on top of the closest. Resident #8 went on to say that depending on who works if the blue foot cradle pillow is placed underneath her feet. On 7/2/25 at 8:40 a.m., Staff A, CNA, verified that a turning/repositioning program means that a resident is turned or repositioned every 2 hours, and that no documentation in the computer program allows the staff to chart that the resident was turned or repositioned and if not on the care plan than she did not know to turn or reposition a resident. On 7/2/25 at 8:45 a.m., Staff B, CNA, verified that the care plan is where she goes to look for a turning/repositioning program and if it is not on the care plan than she does not know a resident has that program, and that the computer has not where for her to document that the resident was turned and repositioned. On 7/2/25 at 9:50 p.m., Staff J, RN, verified that it is the expectation of the staff to turn and reposition a resident every 2 hours and that the computer system has no where for staff to document that the resident was turned or repositioned and to follow the care plan. On 7/2/25 at 12:30 p.m., Staff F, RN, explained that the expectation of the staff are to keep the feet up off the bed by using the blue cradle pillow at all times and to make sure that Resident #8 feet are not touching the foot board. On 7/3/25 at 9:30 a.m., the Director of Nursing, verified that the clinical record lacked any documentation of the staff charting on a turning/repositioning program and that it is expected that staff follow the plan of care to use the blue foot cradle at the end of the bed. 2. The 5-Day Assessment MDS dated [DATE] for Resident #9 reflected that the resident was able to make herself understood and able to understand others. The MDS identified the BIMS score of 14 for which indicated no impaired decision making. The MDS revealed the resident required partial to moderate assistance for upper and lower body dressing and repositioning and dependent for toileting. The MDS revealed these diagnoses, diabetes mellitus, cerebravascular accident, and non-Alzheimer's dementia. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	The Comprehensive Care Plan of Resident #9, with a revision date 12/5/23, revealed the resident to have an Activities of Daily Living (ADL) self care deficit. The Care Plan directed staff the resident required 1 staff assist for transfers, toileting, upper and lower body dressing and personal hygiene. The Focus Area of the Care Plan of skin integrity revealed the resident to have left buttock-friction/shear Moisture Associated Skin Damage (MASD), revision dated 6/17/25. It directed staff to perform treatment to area as ordered per physician orders, pressure reducing mattress to me bed and pressure reducing cushion to wheelchair. The care plan failed to reveal the need to turn the resident side to side in bed or to keep the resident off of her back. The census line of Resident #9 Electronic Health Record (EHR) reflected that the resident was hospitalized from [DATE] to 5/5/25. The Progress note dated 4/28/25 at 2:04 p.m., from the wound consult visit assessment, resident presents today with wound to buttocks. She is alert and oriented, sitting in bed. admitted for weakness and falls. She was able to turn on her side with minimal help. She is on a waffle overlay. Wound from admission photos has mostly healed already. Buttocks are lightly red, blanchable. No pressure injury at this time. Wound looks to have been shearing wound. The Nursing Admission/readmission Evaluation dated 5/5/25 at 3:30 p.m., reflected the skin and wound portion, with no pressure injuries or non pressure wounds. The Health Status Note dated 5/5/25 for Resident #9 reflected the resident to have no non-pressure injury wounds upon returning to the facility from the hospital. The Wound Evaluation form dated 5/5/25 at 12:53 p.m., reflected MASD present on admission, with no measurements and stated that patient arrived with bordered foam dressing on buttocks/gluteal cleft. Once removed, nothing was underneath. The Wound Evaluation form dated 5/12/25 at 2:45 p.m., reflected Incontinence Associated Dermatitis (IAD), present on admission 7 days old with no measurements, and healable. The Wound Evaluation form dated 5/19/25 at 4:54 p.m., reflected IAD, now 14 days old, with measurements of area=177.42 cm by length of 18.8 cm by width of 14.7 cm., with monitoring. The Wound Evaluation form dated 5/21/25 at 4:00 p.m., reflected IAD to coccyx area present on admission with 16 day old. Measurements of area= 0.56 cm by length 1.44 cm by width-0.5 cm. Wound bed is pink or red, surrounding tissue is blanching, fragile and intact, additional care of cushion, foam mattress, incontinence management and mobility aid provided, moisture control and turning/repositioning program. Review of the Treatment Administration Record of Resident #9 for May of 2025 revealed the treatment was not documented as being completed on Wednesday May 21, 2025, Friday May 23, 2025 and Saturday May 24, 2025. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	The Wound Evaluation Form dated 5/28/25 at 2:09 p.m., reflected, MASD-IAD, to coccyx, 23 days old, with measurements of area= 0.91 cm by length=3.59 cm by width= 0.57 cm by deepest point = 0.1 cm. Wound bed is pink or red, additional care of cushion, foam mattress, incontinence management, mobility aid provided, moisture barrier, moisture control and turning/reposition program and is deteriorating and ARNP was notified. The Dietary Note dated 5/9/25 at 12:41 p.m., reflected that skin is free from pressure injuries. The Encounter note dated 6/3/25 with no time, documented resident is seen today for a sore on her bottom. She reports feeling wiped out and has been spending more time in bed than usual. She also reports a sore on her bottom, more pronounced on the left side, which has worsened recently. The patient has been repositioned to her right side more frequently to alleviate pressure. She notes that the padding used for cushion has been uncomfortable and ineffective. Plan: breakdown on buttock due to incontinence exposure, notify provider is area opens or becomes larger, frequent reposition and out of bed in afternoons. During an interview with Resident #9 on 7/2/25 at 2:30 p.m., she stated that her wound care is supposed to be done twice a day and the staff does provide that most days. The MDS of Resident #9 dated 5/9/25 indicated a BIMS score of 14, cognition intact. On 7/2/25 at 3:12 p.m., the DON stated that her expectation is that all interventions are on the care plan and are being followed by the staff and was unable to locate any information that a turning/reposition program was in the documentation survey portion of the clinical record. The policy Pressure Ulcers/Skin Breakdown, review date 4/2018, directed staff as follows: The nursing staff and practitioner will assess and document an individuals significant risk factors for developing pressure ulcers, for example, immobility, recent weight loss, and a history or pressure ulcer. Neither Resident #8 nor Resident #9 had a positioning schedule documented in the Kardex.

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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 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 a document of call light start and end time, resident interview, staff interview, and the facility policy review, the facility failed to consistently answer call lights within a reasonable amount of time for 4 of 4 residents. (#2, #5, #8 and #11) The facility reported a census of 84 residents. Findings include: 1 The Quarterly Minimum Data Set (MDS) dated [DATE] for Resident #2 documented a Brief Interview of Mental Status (BIMS) of 13 indicating no cognitive impairment and has the ability to be understood and understands others. The MDS documented diagnosis of diabetes mellitus, hemiplegia (muscle weakness or partial paralysis on one side of the body that affect the arms legs, and facial muscles) and macular degeneration (an eye disease that can blur your central vision) and required dependence with personal hygiene, transfer and toileting and always incontinent of bladder and bowel. On 6/25/25 at 11:40 a.m., Resident #2 stated that she can read the clock on the wall. Resident #2 stated that it takes longer than 15 minutes to answer the call light. Review of document titled Zone start and end time report revealed call light logs longer than 15 minutes for Resident #2. 6/24/25 7:59 a.m. to 8:18 a.m. 19 minutes 6/24/25 8:44 a.m. to 8:53 a.m. 23 minutes 6/24/25 12:04 p.m. to 12:13 p.m. 19 minutes 6/24/25 6:03 p.m., to 6:20 p.m. 17 minutes 62425 7:22 p.m. to 7:42 p.m. 20 minutes 6/25/25 2:41 p.m. to 3:06 p.m. 25 minutes 6/27/25 11:52 a.m. to 12:11 p.m. 19 minutes 6/27/25 7:18 p.m. to 7:47 p.m. 29 minutes 6/29/25 8:14 a.m. to 8:31 a.m. 17 minutes 6/29/25 11:48 a.m. to 11:55 a.m. 17 minutes 6/29/25 2:47 p.m. to 2:50 p.m. 23 minutes 6/30/25 4:09 p.m. to 4:31 p.m. 22 minutes (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	07/03/2025

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.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. The Quarterly MDS dated [DATE] for Resident #5 documented a BIMS of 13 indicating no cognitive impairment and had the ability to be understood and understands others. The MDS documented diagnosis of diabetes mellitus, cerebrovascular accident, (damage to the brain from interruption of its blood supply) non-Alzheimer dementia, anxiety and depression and required dependence with personal hygiene, transfer, toileting and frequently incontinent of bladder. On 7/1/25 at 10:00 am. Resident #5 stated that it takes longer than 15 minutes to answer her call light and that she is able to see the clock on the wall. Review of document titled Zone start time and end time report revealed call light logs longer than 15 minutes for Resident #5. 6/24/25 6:39 p.m., to 7:02 p.m. 41 minutes 6/25/25 7:18 p.m., to 7:53 p.m. 35 minutes 6/28/25 5:19 a.m. to 5:55 a.m. 36 minutes 3. The Significant Change in status MDS dated [DATE] for Resident #8 documented a BIMS of 9 indicating moderate cognitive impairment and has the ability to be understood and understands others. The MDS documented diagnosis of diabetes mellitus, cerebrovascular accident, (damage to the brain from interruption of its blood supply), anxiety, depression and required dependence with personal hygiene, and substantial to maximal assistance with transfer, toileting. On 7/1/25 at 8:00 a.m., Resident #8 stated that it takes over 30 minutes to answer her call light, and that she is able to see the clock on her wall across from her bed. Review of document titled Zone start time and end time report revealed call light longer than 15 minutes for Resident #8. 6/24/25 8:50 a.m. to 9:14 a.m. 24 minutes 6/24/25 4:13 p.m. to 4:34 p.m. 21 minutes 6/25/25 6:39 a.m. to 6:58 a.m. 19 minutes 6/25/25 7:03 a.m. to 7:21 a.m. 18 minutes 6/25/25 12:22 p.m. to 12:44 p.m. 22 minutes 6/25/25 2:10 p.m. to 2:30 p.m. 20 minutes 6/25/25 2:45 p.m. to 3:09 p.m. 24 minutes 6/25/25 7:09 p.m. to 7:43 p.m. 34 minutes 6/26/25 12:02 p.m., to 12:47 p.m. 45 minutes (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	07/03/2025

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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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	6/26/25 1:37 p.m. to 2:07 p.m. 44 minutes 6/26/25 7:01 p.m., to 8:44 p.m. 45 minutes 6/27/25 12:28 p.m. to 2:24 p.m. 2 hours 52 minutes 6/27/25 2:30 p.m. to 4:26 p.m., 2 hours, 26 minutes 6/27/25 7:48 p.m., to 8:28 p.m. 40 minutes 6/28/25 9:13 a.m. to 9:55 a.m. 42 minutes 6/28/25 12:52 p.m., to 1:30 p.m. 38 minutes 6/28/25 5:07 p.m. to 5:47 p.m. 40 minutes 6/29/25 8:30 a.m. to 9:24 a.m. 54 minutes 4. The Annual MDS dated [DATE] for Resident #11 documented a BIMS of 15 indicating no cognitive impairment and has the ability to be understood and understands others. The MDS documented diagnosis of diabetes mellitus, hemiplegia, anxiety, depression, schizophrenia and required substantial to maximal assistance with activities of daily living. On 6/30/25 at 3:15 p.m., Resident #11 stated that it takes over 15 minutes to have his call light answered and is able to time the response due to seeing the clock on the wall. Review of document titled Zone start and end time report revealed call light longer than 15 minutes for Resident #11. 6/25/25 6:12 p.m. to 6:51 p.m. 39 minutes 6/26/25 4:33 p.m., to 4:58 p.m. 25 minutes 6/27/25 11:50 a.m. to 12:12 p.m., 22 minutes 6/28/25 4:34 p.m. to 4:56 p.m. 22 minutes 6/29/25 10:03 a.m. to 10:25 a.m. 22 minutes On 7/1/25 at 3:15 p.m., the Administrator and Director of Nursing stated the facility expectation is that call lights are answered in 15 minutes or less. On 7/2/25 at 9:15 a.m., Staff A, Certified Nursing Assistant (CNA), stated that it takes longer than 15 minutes to answer a resident call light due to low staffing. On 7/2/25 at 9:30 a.m., Staff B, CNA, stated that it takes longer than 15 minutes to answer a resident call light. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of a policy titled Call Light Answering dated 3/2021 provided by the Administrator revealed that the purpose of the policy was to meet the resident's needs and requests within an appropriate time frame. Call lights will be answered within 15 minutes.