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	01/07/2026

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on clinical record review, policy review, and staff interview, the facility failed to treat 1 of 7 residents (Resident #1) reviewed for dignity with respect by applying multiple incontinent briefs during personal hygiene care. The facility reported a census of 38 residents. Findings included: The 11/21/25 Minimum Data Set(MDS) assessment tool, listed diagnoses for Resident #1 which included sepsis(an infection of the blood), weakness, the need for assistance with personal care. The MDS listed the resident's Brief Interview for Mental Status(BIMS) score as 15 out of 15, indicating intact cognition. The MDS stated the resident was dependent on staff for toileting hygiene and toilet transfers. The facility policy Dignity, revised February 2021, stated the facility would care for residents in a manner that promoted and enhanced a sense of well-being, level of satisfaction with life , and feelings of self-worth and self-esteem. 8/25/25 Care Plan entries stated the resident required the assistance of 2 staff for toilet transfers. The entries stated the resident had urinary incontinence and directed staff to assist him to the bathroom and with cleansing. An 11/29/25 Transfer Form stated the resident transferred to the hospital at 10:20 a.m. The resident's Census report documented the resident resided in the 300 Hall on 11/29/25. The Daily Nursing Assignments for 11/29/25 documented Staff C Certified Nursing Assistant(CNA) assigned to the 300 Hall during the 6:00 a.m. to 2:00 p.m. shift on 11/29/25. The November 2025 Documentation Survey Report v2 documented Staff C provided cares for the resident on the 6:00 a.m. to 2:00 p.m. shift on 11/29/25. A 12/2/25 Hospital Shift Summary stated the resident arrived (at the hospital) in 3 pairs of grossly soiled diapers with skin damage.A 12/9/25 Internal Investigation Witness Statement documented that the Director of Nursing(DON) interviewed Staff C. Staff C stated that she took care of the resident on Saturday morning(11/29/25). On 1/6/26 at 11:00 a.m. Staff A CNA stated when she first started at the facility, Staff C directed her to place more than 1 brief on residents. She stated she did not think this was a good idea so did not do this herself. On 1/6/26 at 11:09 a.m. Staff B CNA stated she told Staff C not to place more than one brief on residents because it could make them sick. She stated that she saw Staff C care for Resident #1 in this manner and the last time she told her not to do this was on 11/28/25. Staff B stated she did not report this right away because she thought it would affect Staff C's job. Staff B stated she received education regarding mandatory reporting. On 1/6/26 at 3:22 p.m., the DON stated staff should only apply one brief to residents unless their plan of care directed differently. She stated Resident #1's care plan did not include the use of more than one incontinent brief.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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** Based on clinical record review, policy review, and staff interview, the facility failed to carry out assessments for 1 of 3 residents reviewed for a change in condition(Resident #1) by failing to carry out timely skin assessments after a hospitalization. The facility reported a census of 38 residents. Findings included:The 11/21/25 Minimum Data Set(MDS) assessment tool, listed diagnoses for Resident #1 which included sepsis(an infection of the blood), weakness, and the need for assistance with personal care. The MDS listed the resident's Brief Interview for Mental Status(BIMS) score as 15 out of 15, indicating intact cognition. The facility policy Pressure Ulcers/Skin Breakdown-Clinical Protocol, revised April 2018, stated the nursing staff would examine the skin of newly admitted residents for evidence of existing pressure ulcers or other skin conditions. A 9/8/25 Care Plan entry directed staff to monitor and document location, size, and treatment of skin injuries and to report abnormalities. 11/18/25 Care Plan entries stated the resident had moisture associated skin damage to the buttocks. 11/29/25 Nurses Notes stated the facility received an order to send the resident to the hospital for evaluation and he admitted for sepsis. A 12/5/25 Nurses Note stated the resident readmitted to the facility. The resident refused a full skin check because he wanted to stay in his chair for dinner.The facility lacked documentation staff reapproached the resident regarding a skin check to include the resident's buttocks between his readmission on [DATE] and 12/8/25. A 12/8/25 Skin Issues Note stated the resident had a new skin issue to the buttocks which measured 0.9 centimeters(cm) x 0.58 cm(length x width) with a pink/red wound bed.On 1/6/26 at 9:36 a.m. the facility Wound Nurse stated the nurse who completed resident admissions was in charge of completing a head to toe skin assessments. She stated with Resident #1, she knew the skin issues he had and there was a potential for deterioration. She stated because of this, she completed an assessment herself on 12/8/25. She stated there was likely the assumption the admitting nurse completed the assessment and that was why other staff did not follow up. On 1/6/26 at 3:22 p.m., the Director of Nursing(DON) stated staff should perform skin assessments on the day of admission and if it is not done, staff should pass this information along to the next shifts. If a resident refused a skin check, staff should offer to attempt again.