STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165345	A. Building B. Wing	05/21/2026

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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on direct observation, clinical record review, facility policy review, resident and staff interview, the facility failed to treat residents with dignity and respect. An observation revealed a member of the therapy team ignored the wishes of the resident for 2 of 7 residents screened for dignity related concerns (Residents #13 and #14). The facility reported a census of 86.Findings include: 1. Resident #13's Minimum Data Set (MDS) dated [DATE] identified a Brief Interview for Mental Status (BIMS) score of 13, indicating intact cognition. The MDS included diagnoses of heart failure, hypertension (high blood pressure), orthostatic hypotension (low blood pressure upon standing), renal insufficiency (kidney failure), malnutrition, asthma, unsteadiness on feet, generalized muscle weakness, abnormality of gait and mobility.The Care Plan for Resident #13 identified they received Physical and Occupational Therapy services.On 5/14/26 at 12:51 PM Resident #13 identified Staff J, Physical Therapist (PT), and said they weren't a fan of Staff J providing Physical Therapy services because Staff J pushed too hard, often ignoring them when they said they couldn't stand anymore. Resident #13 described Staff J as rude and pushy, and stated other residents complained to them about Staff J.2. Resident #14's Minimum Data Set (MDS) assessment dated [DATE] identified a BIMS score of 15, indicating intact cognition. The MDS included diagnoses of renal insufficiency, diabetes mellitus (diabetes), chronic pain, malignant neoplasm of bone (bone cancer), bilateral lumbago with sciatica (back pain and sciatic nerve pain impacting both legs), chronic pain.The Care Plan identified Resident #14 currently received Physical and Occupational Therapy services.On 5/14/26 at 12:27 PM Staff J provided therapy services for an unidentified resident. Staff J ignored 3 separate requests from the resident to sit down. The resident cried out I need to sit, but Staff J repeated Just keep going several times with a flat affect. Staff J placed a wheelchair underneath the resident once they began to lose balance.On 5/14/26 at 9:58 PM Resident #14 named Staff J directly and stated they felt Staff J was rude and pushy. Resident #14 shared an encounter with Staff J in which they asked for some water and Staff J told them, they had to say please before they could get some water. Resident #14 reported being out of breath at the time. Resident #14 described Staff J as always rude and condescending, and it makes them feel like Staff J doesn't care.On 5/14/26 at 3:27 PM Staff J described the therapy process as a tough love situation, and stated that's how they encourage residents, though Staff J agreed not all residents find it encouraging.On 5/18/26 at 3:13 PM Staff H, Registered Nurse (RN), stated residents should always be treated with kindness and respect, and Staff H always tried to honor a resident's wishes and requests for help.On 5/18/26 at 3:46 PM Staff D, Certified Medication Aide (CMA), stated the standard is to approach residents respectfully, and if a resident didn't find the approach respectful, Staff D's willing to apologize and reapproach.On 5/18/26 at 4:18 PM Staff K, Certified Nurse Aide (CNA), stated Staff K wants residents to be treated like family, and that means listening to them, honoring their wishes.On 5/20/26 at 1:23 PM the Area Director of Operations (ADO) stated some residents do need something that could be described as tough love. After explanation of the witnessed situation, the ADO clarified the resident should've been allowed to sit down when requested, not when they start to lose their balance.On 5/20/26 at 10:30 (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	AM the Director of Nursing (DON) clarified Staff J's a contracted therapy staff, and not a direct facility staff member. The DON reported they expected all staff, contracted or not, to treat residents with respect and compassion. The DON agreed Staff J should've handled the situation differently, and agreed it's a concern.The Dignity policy revised February 2021 directed residents are treated with dignity and respect at all times.

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, clinical record reviews, and facility policy review, the facility failed to have an order for a resident to self-administer their own medications before leaving them unattended with Miralax for 2 of 2 residents observed (Residents #10 and #16). The facility reported a census of 86. Findings include:Findings include:1. Resident #10's Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition.The Physician Orders included an order dated 4/18/26 to give Miralax (powdered medication mixed with liquid) one time per day for constipation. The Physician Orders didn't include an order to allow Resident #10 to self-administer medications.On 5/12/26 at 12:27 PM Staff E, Certified Medication Aide (CMA), left a cup of prepared Miralax with Resident #10. By the end of lunch service, Resident #10 hadn't consumed the Miralax, and it's left behind on the table. Dietary staff eventually threw away the cup of Miralax as they cleaned up from the meal service.Resident #10's May 2026 Medication Administration Record (MAR) documented Resident #10 took the Miralax as ordered on 5/12/26.On 5/14/26 at 2:38 PM Staff E explained Resident #10's usually pretty good with taking Miralax but refuses every once in a while. Staff E reported Resident #10 took the medication on 5/12/26 and visually confirmed the cup's empty. When informed Resident #10 hadn't consumed the Miralax, Staff E stated they may've looked at a different empty cup.2. Resident #16's Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) score of 7, indicating severe cognitive impairment.The Physician Orders included an order dated 6/29/24 directed staff to give Miralax one time per day for constipation. The Physician Orders didn't include an order to allow Resident #16 to self-administer medications.On 5/14/26 at 6:50 AM watched Staff D, CMA, prepared Miralax for Resident #16. Staff D mixed the medication with approximately 8 ounces of water. Staff D took the Miralax and other oral medications into Resident #16's room to administer. Resident #16 took all oral medications, drank a few sips of Miralax, and placed the remaining amount on the bedside table. Staff D left the room with the unfinished Miralax sitting on the bedside table. Afterwards, Staff D explained Resident #16 didn't like to drink the Miralax all at once and sipped on it throughout the morning. Staff D noted Resident #16 took additional medications in the late morning and they would ensure Resident #16 consumed the Miralax.On 5/14/26 at 4:00 PM the Director of Nursing (DON) acknowledged staff left Miralax in Resident #16's room unattended, which isn't acceptable. The DON stated the Miralax timing or how staff presented it could be adjusted to better meet resident needs and preferences, such as offering the Miralax in smaller sips as Resident #16 takes each oral medication separately.On 5/20/26 at 10:30 AM the DON explained staff administering medications should stay with the resident and watch them to ensure they took all of their medications.The Administering Medications policy revised April 2019 directed the following: a. Medications are administered in accordance with prescriber orders, including any required time frame. b. Medication administration times are determined by the resident need and benefit and not staff convenience. c. Medications are administered within one hour of their prescribed time, unless otherwise specified. d. Residents may self-administer their own medications only if the Attending Physician, in conjunction with the Interdisciplinary Care Planning Team, has determined that they have the decision-making capacity to do so safely.

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, facility policy review, resident and staff interview, the facility failed to uphold the established grievance process when staff members failed to report repeated resident grievances to management. The facility reported a census of 86.Findings include:Review of Grievance Logs from January 2026 through May 2026 documented at least 7 instances of lost or missing resident items, with 3 of them documenting missing clothing.1. On 5/12/26 at 11:39 AM Resident #1's Representative stated the family is constantly reporting missing clothing to the Certified Nurse Aides (CNAs). Resident #1's Representative stated they have clothing go missing so often they have started buying outfits every week to keep up.2. Resident #11's Minimum Data Set (MDS) assessment dated [DATE] documented Resident #11's entry date as 4/1/26. The MDS identified a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition.On 5/12/26 at 3:17 PM Resident #11 stated he lost T-shirts when he first entered the building on 4/7/26. He stated he knew he'd told someone, but it'd been so long he gave up on getting them back.3. On 5/12/26 at 4:24 PM Resident #2's Representative stated their loved one's clothes are going missing so often the family is having to spend good money just to ensure their loved one has clothes at all. Resident #2's Representative stated they told a number of staff members but they have gave up on getting any of it back, and it felt like no one takes them seriously.On 5/13/26 at 2:54 PM Resident #3's Representative stated they have notified the facility of numerous items this year alone that have gone missing. Resident #3's Representative stated the most recent is a wallet/purse that has been missing for several weeks, and she knows she told CNAs about the issue but it hasn't been addressed.4. On 5/14/26 at 8:42 AM Resident #4 Representative stated clothing takes a very long time to come back from laundry if it comes back at all. Resident #4 Representative stated she looked for clothing herself in the laundry room and couldn't find what's missing, but noted she'd seen other residents wearing clothes she suspected belonged to her family members.5. Resident #13's Minimum Data Set (MDS) assessment dated [DATE] identified a BIMS score of 13, indicating intact cognition.On 5/14/26 at 12:51 PM Resident #13 stated she's currently missing a number of articles of clothing, and stated she has told CNAs that they are missing. She stated she hasn't had anyone find the items or address the issue with her. Resident #13 stated the last time she brought it up to laundry they brought a small cart of items to her to look through, but she couldn't find the missing articles.6. On 5/15/26 at 1:29 PM Resident #5's Representative stated her loved one had clothes go missing that never returned. Resident #5's Representative stated the facility would take the clothes when they were soiled to wash them and often times, they would just not get them back. Resident #16 Representative knows she reported this, but it wasn't addressed.On 5/18/26 at 4:18 PM Staff K, CNA, stated residents have complained to her about missing clothing. Staff K stated when a resident complained about missing clothing she talked to laundry and if they can't find it, sometimes she tells her supervisor and sometimes she doesn't.On 5/18/26 at 3:46 PM Staff D, Certified Medication Aide (CMA), stated residents have complained to her about their clothing going missing. Staff D stated the laundry department can be slow about labeling things. Staff D stated when a family complained to her about laundry missing, she takes them to the laundry lost and found when able, but she didn't what the procedure is after that if they can't find the missing clothes.On 5/18/26 at 3:13 PM Staff H, Registered Nurse (RN), stated she had residents complain to her about missing laundry. Staff H stated she tried to resolve the issue by informing laundry and assisting them in looking for the missing items before getting leadership involved, but she didn't know when she should get leadership involved.On 5/13/26 at 1:45 PM observed a large amount of lost-and-found laundry, filling a small room with overflow kept in numerous plastic totes in the primary laundry room.On 5/13/26 at 1:45 PM the Laundry Supervisor (LS) stated the facility holds on to missing laundry for a period of about 6 (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	months, after which staff members are free to take it home or donate it outside of the facility. LS stated she made every effort to locate the clothing before that period of time passed. LS acknowledged she got some reports of missing items, but couldn't articulate when she should get facility leadership involved.On 5/20/26 at 4:05 PM the Administrator stated anyone can fill out a grievance form. The Administrator reported they expected staff members to fill out a grievance form when they can't immediately find something that has been misplaced. The Administrator acknowledged this should've been done in each case for missing clothing.The Facility Policy and Procedure dated May 2026 directed a subsection of Grievance Procedure, does not contain instructions for staff members reporting complaints or grievances to facility leadership. It addresses the complaint process for non-staff members.

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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, resident interviews, staff interviews, and policy review, the facility failed to complete resident assessments for 2 of 2 residents reviewed for assessment and interventions (Residents #3 and #4). Resident #3 lacked the completion of neurological checks (neuros) after an unwitnessed fall. Resident #4 lacked nursing assessment and follow-up post same-day surgery. The facility reported a census of 86.Findings include:1. Resident #4's Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) score of 12, indicating moderate cognitive impairment. Resident #4 depended on staff for personal care needs (bathing and toileting) and relied on a wheelchair for ambulation. The MDS included diagnoses of acute kidney failure, diabetes, and incontinence. The Nurses Note dated 2/27/26 at 12:22 PM indicated the Advanced Registered Nurse Practitioner (ARNP) completed a pre-operative physical on Resident #4 related to same-day surgical procedures scheduled for 3/12/26. Procedures included assessments of the urinary bladder and urinary tubes, laser lithotripsy (kidney stone removal), and urinary stent exchange. The Alert Note dated 3/11/26 at 11:39 AM identified check in for surgery on 3/12/26 at 11:30 AM. The Orders - Administration Note dated 3/11/26 at 11:35 PM reflected Resident #4 had a nothing by mouth (NPO) status for their procedure on 3/12/26. The Patient Visit Information indicated Resident #4 received instructions with the packet on 3/12/26 at 3:26 PM. The instructions directed in handwriting to remove their stent on Monday. The Appointment/Visit Note dated 3/12/26 at 4:53 PM documented Resident #4 returned to the facility after a same-day surgical procedure. Resident #4's daughter gave paperwork to the nurse. The Encounter Note dated 3/13/26 at 12:00 AM the ARNP completed a post-operative visit and noted Resident #4 had kidney stones removed the day before. The Nurses Note dated 4/7/26 at 5:47 PM documented a urinary stent removal. Resident #4 tolerated it well with no issues noted. The clinical health record lacked post-surgical physician orders and nursing assessments upon Resident #4's return to the facility on 3/12/26. There weren't documented care instructions or any additional follow-up assessments related to the procedure. The Progress Note on 4/7/26 was the first documented nursing entry identified related to the surgical procedure on 3/12/26. On 5/13/26 at 4:15 PM Staff A, Registered Nurse (RN), recalled Resident #4 when returned to the facility from the same-day procedure. However, they weren't the nurse responsible for entering the new orders. Staff A explained afterwards they were off work for an extended time. Upon their return, Staff A learned Resident #4 still had their urinary stent in place. Staff A explained this is typically removed shortly after a procedure and made arrangements for this to be removed immediately. Staff A acknowledged the clinical health record lacked nursing assessment post-procedure for Resident #4. Ideally, when residents return from procedures like this, nursing staff would take at least a set of vitals and complete an assessment. Nursing staff would pass the information along and each nursing shift would monitor and document an assessment of the resident for the next 72 hours via Hot (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Charting. On 5/13/26 at 4:30 PM the Director of Nursing (DON) recalled discussions with nursing staff regarding Resident #4's procedures prior to the surgery date and the presence of a urinary stent upon their return. The DON reviewed how the stent should be removed and to reach out if any further questions or concerns with removal occurred. The DON stated staff alerted them to the presence of the urinary stent on 4/7/26. They ensured nursing staff completed an assessment prior to the stent removal. The DON reviewed Resident #4's Patient Visit Information from 3/12/26 and acknowledged the stent should've been removed prior to 4/7/26. Upon a resident's return, nursing staff should review for any orders. If none are provided, staff should contact the medical provider. Nursing staff should also complete an assessment, including vitals and visualization of the surgical site. Further nursing assessments and follow-up related to the surgery should be completed for the next 3 days. On 5/18/26 at 3:57 PM the facility's Medical Director explained urinary stents are typically removed about a week after placement. If indicated by the urologist, it can remain longer. The Medical Director confirmed the facility staff didn't contact them regarding the stent and was aware it wasn't removed after a week. The Change in Resident's Condition or Status policy revised February 2021 directed the following: a.The nurse will notify the resident's attending physician or physician on-call when there has been a significant change in the resident's physical/emotional/mental condition or need to alter the resident's medical treatment significantly. b.The nurse will record in the resident's medical record information relative to changes in the resident's medical/mental condition or status. 2. Resident #3's Minimum Data Set (MDS) discharge assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) score of 9, indicating moderately impaired cognition. The MDS included diagnoses of difficulty in walking, cognitive communications defect, Wernicke's Encephalopathy (brain damage caused by vitamin B1 deficiency), weakness, need for assistance with personal cares, and generalized muscle weakness. The Care Plan revised 5/1/26 documented Resident #3 had a risk for falls. The Incident, Accident, Unusual Occurrence Note dated 3/10/26 at 8:00 PM identified a Certified Nurses' Aide (CNA) told the nurse about Resident #3 on the floor. The Unwitnessed Fall report dated 3/10/26 at 8:00 PM The Communication – with Physician dated 3/13/26 at 3:05 AM documented notification to the physician of Resident #3's fall. The Incident, Accident, Unusual Occurrence Note dated 4/23/26 at 10:00 PM reflected during a tornado watch, Resident #3 attempted to self-transfer and lost her balance. The staff found her on her right side with a cut on her lip and redness on the right side of her face. He pupils were nonreactive on out right eye. The provider gave okay to send out. The Neurological Eval dated 4/23/26 at 8:45 PM printed 5/13/26 lacked signatures for the first 9 sections. Section 10 and 11 included signatures dated 5/11/26. Section 12 (third 8-hour check) was signed 4/25/26. Section 13 and 14 remained blank with section 15 (sixth 8-hour check) signed 4/26/26. Section 16 and 17 remained blank and Section 18 got signed 4/27/26. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The SPN – Focused Evaluation dated 4/24/26 at 2:45 AM indicated Resident #3 returned from the hospital after her fall the night before. The CT Scan (specialized imaging) was negative. On 5/18/26 at 3:13 PM Staff H, RN, stated neurochecks are to be initiated immediately upon a resident having an unwitnessed fall. She clarified if the resident is sent out to the emergency room, neurochecks should resume as soon as the resident returned from the hospital and should be completed in sequence after that. On 5/20/26 at 10:30 AM the DON stated she expected staff to resume neurochecks at the time they returned to the facility. She clarified the nurse who should've started the neurochecks process had resigned from the facility and had been unavailable for follow-up after Resident #3's fall. The Neurological Assessment policy revised October 2010 directed neurological assessments are indicated in cases where a resident has an unwitnessed fall or a fall involving head trauma.

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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** Based on observations, clinical record review, resident interviews, staff interviews, and policy review, the facility failed to provide adequate resident supervision during severe weather warning as well implement Care Plan interventions after a series of falls (Resident #16) for 1 of 9 residents reviewed for supervision. The facility reported a census of 86. Findings include:Resident #3's Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) score of 9, indicating moderately impaired cognition. The MDS included diagnoses of difficulty in walking, cognitive communications defect, Wernicke's Encephalopathy (brain damage caused by vitamin B1 deficiency), weakness, need for assistance with personal cares, and generalized muscle weakness. The Care Plan revised 5/1/26 documented Resident #3's had a risk for falls. The Care Plan included the following Interventions:a. 4/23/26: Resident #3 had anxiety during tornadoes, please don't leave her unattended. b. 3/11/26: obtain a UA (urinary analysis) with a culture and sensitivity (C&S).c. 3/12/26: Obtain UA with C&S and treat. The Incident, Accident, Unusual Occurrence Note dated 4/23/26 labeled Late Entry indicated Resident #3 sat in their recliner during an active tornado warning with a call light nearby. Resident #3 attempted to self-transfer and lost her balance. The staff found Resident #3 on her right side with a cut on her lip and redness on her face. She had nonreactive pupils on her right eye. Attempts to contact the nurse who responded to Resident #3's fall on 4/23/26 occurred, but the nurse no longer worked at the facility and didn't respond to the contact attempts. On 5/18/26 at 3:13 PM Staff H, Registered Nurse (RN), stated cognitively disabled residents don't have the right to put themselves in dangerous situations. Staff H stated she didn't work the night of the tornado, but she'd have kept residents with cognitive disabilities close and make sure they're supervised and accounted for to keep them safe. On 5/18/26 at 3:46 PM Staff D, Certified Medication Aide (CMA), stated she didn't work the evening of the tornado. Staff D stated they're instructed to put cognitively disabled residents in a safe place where they can be monitored and assign staff to residents to ensure they have help close at hand. Staff D stated for their safety, residents prone to wandering or getting up on their own should be watched during the emergency. On 5/18/26 at 4:18 PM Staff K, Certified Nurse Aide (CNA), stated they assign staff members to people with dementia and other illnesses that impact cognition during disasters like tornadoes to keep them safe, but clarified she didn't work the evening of the tornado. On 5/18/26 at 4:39 PM Staff L, CNA, stated during disasters like the tornado, staff are instructed to take residents with dementia and other cognitive impairments to a shower room or other large safe area to ensure they have supervision during the disaster. On 5/20/26 at 10:30 AM the Director of Nursing (DON) stated she didn't have a good answer as to why supervision wasn't provided to Resident #3 during the disaster and agreed it should've been provided. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Severe Weather, Tornado Site Plan policy lacked instructions for cognitively disabled residents or residents who are prone to wandering.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, facility policy review, clinical record review, staff, and Resident Representative interviews, the facility failed to follow-up after a significant change in weight in short period of time for 2 of 2 residents reviewed (Residents #2 and #11). Both residents had significant changes in weight in less than a month. The facility reported a census of 86 residents. Findings include:1. Resident #2's Minimum Data Set (MDS) assessment dated [DATE] he MDS included diagnoses of diabetes mellitus (diabetes), cerebrovascular accident (stroke), hemiplegia or hemiparesis (partial paralysis), malnutrition, and oropharyngeal phase dysphagia (difficulty swallowing). It documented Resident #2 had an enteral feeding tube due to difficulty swallowing and had lost weight due to an inability to intake food normally.The Care Plan revised 4/14/26 documented Resident #2 had an altered nutritional status due to partial paralysis after a stroke. It instructed staff members to obtain weights as ordered by the physician and per facility policy due to the resident's altered nutritional status.The Weight Summary printed 5/20/26 included the following weights:a.2/11/26: 223.0 pounds (lbs.)b.3/14/26: 220.44 lbs.c.4/4/26: 208.2 lbs.d.4/22/26: 206.1 lbs.From 3/14/26 to 4/4/26, Resident #2 had a weight loss of 12.24 lbs. or 5.553%.The SPN-Nursing/Therapy Communication dated 3/11/26 at 2:25 PM listed a recommendation to discontinue enteral feed and continue with puree and thin liquids - encourage Resident #2 to be up for meals. The Dietary Note dated 4/1/26 at 10:48 AM indicated Resident #2 ate a regular no added salt (NAS) diet, with a level 4 pureed texture, a level 0 thin consistency. His intakes ranged from 0-100% with 14 meal refusals. He took in 0-480 milliliters (ml) and a daily bedtime (HS) snack as desired within the past 30 days. The RD recommended to encourage nutrient dense intakes and offer meal or snack alternates as needed. Continue current nutritional interventions as accepted. Notify the RD of nutritional concerns or changes.The Encounter Note dated 4/6/26 at 12:00 AM regarding an acute/follow-up included the weight from 3/14/26 of 220.44. The note lacked documentation of changes in weight.The Alert Note dated 4/8/26 at 7:26 PM reflected Resident #2 ate 25% or less for 2 or more meals in the day. The facility notified the provided on 3/31/26 and 4/5/26. Resident #2's oral intake appeared to improve. The note listed no new orders (NNO). The SPN - Care Plan Conference dated 4/15/26 at 10:37 AM listed the attendees as the MDS Nurse, the Social Services Designee, and the Activity Director, the family or resident didn't attend. The note reflected Resident #2 had a significant weight loss of over 5% in 30 days. The note lacked documentation of if the weight was expected or planned. He received a nutritional supplement 3 times a day (TID). The Social Services Note dated 4/16/26 at 4:23 PM indicated the facility spoke with Resident #2's Daughter about him discharging to home. The note lacked notification of Resident #2's weight loss.The SPN - Weight Change Notification dated 4/28/26 at 12:44 PM documented a weight of 206.1 as of 4/22/26. Resident #2 had a weight change of 6.5% within 1 month and a 7.5% loss within 3 months. Resident #2 ate 0-100% with a diet of regular NAS, pureed texture, and a thin consistency. His current Interventions were for 4 oz house supplement TID. The SPN-Nursing/Dietary Communication dated 4/28/26 at 12:44 PM listed RD recommendations of 3 oz nutritional juice drink TID with meals.Resident #2's clinical record lacked documentation of an Intervention related to a change in weight from 4/4/26 - 4/28/26.On 5/14/26 at 1:29 PM Resident #2's Representative stated during Resident #2's stay in the facility they noticed him losing weight. They'd mentioned it to staff but didn't know for sure if they did anything. When asked about the type of feeding Resident #2 received, they noted the machine used to provide the enteral feeding would beep often and they'd have to go get nursing staff to fix the problem, which would often take some time.2. Resident #11's Minimum Data Set (MDS) entry assessment dated [DATE] the MDS included diagnoses of diabetes, stroke, and esophageal obstruction (blocked food pipe). It documented the presence of a feeding tube.The Care Plan revised 5/13/26 documented Resident #11 had a potential for altered nutritional status due to the presence of an enteral feeding tube. It instructed staff to obtain weights as ordered and per (continued on next page)

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	165345	A. Building B. Wing	05/21/2026

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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	facility policy.Review of the clinical records titled Weight Summary report revealed Resident #11 lost 27.6 pounds from 4/29/26 to 5/1/26.On 5/12/26 at 3:15 PM observed Resident #11's Representative talking to an unknown nurse and informed them Resident #11's enteral feeding tube wasn't functioning. The observation continued from 3:17 PM. During that time, witnessed Resident #11's enteral feeding not functioning until addressed by staff at 3:42 PM.On 5/12/26 at 3:17 PM Resident #11 and Resident #11 Representative stated it takes a significant amount of time to get staff members to address issues with his enteral feeding tube. Resident #11 believed he'd lost approximately 30 pounds in a short span, though he wasn't sure this was accurate.On 5/14/26 at 9:25 AM the Dietitian stated reweights should take place no later than 7 days after the initial weight showed a potential issue. She confirmed the weight loss for Resident #2 did constitute an issue and noted it could be challenging to get staff members to perform reweighs, though she didn't know why. She stated she's seen a trend in the facility where the standard of 7 days isn't being followed.On 5/14/26 at 11:06 AM Staff M, Certified Nurse Aide (CNA), stated staff members struggled to get reweighs done because staff members are too busy. She stated reweighs aren't as important as providing other care for residents, and it's something that gets cut when they are short-staffed.On 5/18/26 at 3:13 PM Staff H, RN, stated when a resident's weight is higher or lower than 2 pounds different from the last weight, it's standard procedure to reweigh the resident after notifying the provider. She acknowledged this didn't always happen.On 5/20/26 at 10:30 AM the DON acknowledged the sudden weight loss should've triggered a reweigh and noted she didn't have a good answer as to why it didn't happen.The Weight Assessment and Intervention policy revised September 2008 directed any weight change of 5% or more since the last weight assessment will be retaken the next day for confirmation. If the weight is verified, nursing will immediately notify the Dietitian in writing. Verbal notification must be confirmed in writing.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on direct observation, clinical record review, staff and resident interview, and facility policy review the facility failed to maintain adequate staffing to ensure residents had access to timely requests for help, as noted by excessively long call light times. The facility reported a census of 86. Findings include: 1. On 5/12/26 from 3:15 PM until 3:43 PM a continuous direct observation identified a call light for Resident #11 continuously engaged, only changing status at 3:43 PM when a staff member finally entered the room. Review of clinical records from this incident didn't document a call light. Resident #11 confirmed he pushed the call light. On 5/12/26 at 3:45 PM Resident #11 stated the staff member observed responding to the light at 3:43 PM was the first staff member to address his light.On 5/12/26 at 3:17 PM Resident #11 and Resident #11's Representative stated call lights take a significant amount of time, often lasting well over 15 minutes. Resident #11 stated It can take a while to get people in here. He added during times of high demand no one comes when he presses his call light, and Resident #11 Representative supported his statement.2. On 5/13/26 at 8:10 AM Resident #13 reported she has waited over an hour for assistance with her call light. She stated she's concerned the facility didn't have enough staff, and she noted weekends and the overnight shift are the worst when it comes to staffing.The Zone Activity Report 5/8/26 through 5/14/26 for room [ROOM NUMBER] documented the call light response time greater than 15 minutes on 5/12/26 at 4:50 PM until 5:19 PM, 29 minutes.The Zone Activity Report 5/8/26 through 5/14/26 for room [ROOM NUMBER] documented the following call light response times greater than 15 minutes:a. 5/8/26 i. 7:38 AM to 8:04 AM, 26 minutes ii. 9:13 AM to 9:31 AM, 18 minutesb. 5/9/26 i. 9:54 AM to 10:27 AM, 33 minutes ii. 1:46 PM to 2:11 PM, 25 minutesc. 5/10/26 i. 4:41 PM to 5:17 PM, 36 minutesd. 5/13/26 i. 6:43 PM to 7:01 PM, 18 minutesThe Zone Activity Report 5/8/26 through 5/14/26 for room [ROOM NUMBER] documented the following call light response times longer than 15 minutes:a. 5/8/26 i. 7:36 PM - 8:05 PM, 29 minutesb. 5/11/26 i. 5:20 PM - 5:56 PM, 36 minutesc. 5/12/26 i. 1:01 PM - 1:34 PM, 33 minutesd. 5/13/26 i. 11:34 PM - 11:59 PM, 25 minutese. 5/14/26 i. 5:49 PM - 6:07 PM, 18 minutesThe Zone Activity Report 5/8/26 through 5/14/26 for room [ROOM NUMBER]A included a call light response time greater than 15 minutes on 5/14/26 from 3:09 PM until 3:28 PM, 19 minutes.The Zone Activity Report 5/8/26 through 5/14/26 for room [ROOM NUMBER] A included the following call light response times greater than 15 minutes:a. 5/8/26 i. 12:43 PM - 1:05 PM, 22 minutes ii. 6:50 PM - 7:07 PM, 17 minutesThe Zone Activity Report 5/8/26 through 5/14/26 for room [ROOM NUMBER] B listed the following call light response times greater than 15 minutes:a. 5/19/26 i. 8:17 AM - 8:52 AM, 35 minutesb. 5/11/26 i. 8:39 AM - 9:06 AM, 27 minutesc. 5/12/26 i. 4:42 PM - 5:00 PM, 18 minutesd. 5/13/26 i. 9:02 AM - 9:21 AM, 19 minutes ii. 6:26 PM - 6:54 PM, 28 minutes iii. 7:12 PM - 7:32 PM, 20 minutesThe Zone Activity Report 5/8/26 through 5/14/26 for room [ROOM NUMBER] listed the following call light response times greater than 15 minutes:a. 5/9/26 i. 7:59 PM - 8:21 PM, 22 minutesb. 5/13/26 i. 4:53 PM - 5:23 PM, 30 minutes ii. 8:03 PM - 8:23 PM, 20 minuteOn 5/18/26 at 3:13 PM Staff H, Registered Nurse (RN), stated the facility standard is 10 minutes for a standard call light and 5 to 7 minutes for a bathroom call light. She stated this is better than the federally mandated 15 minutes. She stated while much of the time staffing's good, weekends are horribly understaffed and she's had residents complain to her about the long wait times.On 5/18/26 at 3:46 PM Staff D, Certified Medication Aide (CMA), stated the call light timeframes in the facility are 5 minutes for the bathroom and 15 minutes or less for everything else. She stated she didn't know if the call light system's accurate, she knows it had issues and made mistakes before. She noted when she reset the call lights sometimes, they stay on for a long period of time.On 5/20/26 at 10:30 AM the Director of Nursing (DON) stated she has provided substantial education on the 15-minute regulatory requirement for call lights, and noted it's something the facility's still working on. She noted the facility's still (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	hiring staff members and providing education, and acknowledged it isn't appropriate for such long call lights to occur.The Answering the Call Light policy revised March 2021 directed it does not address appropriate call light timeframes. It states the purpose for the policy is to ensure timely response to the residents' requests and needs.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, clinical record review, staff interview, and facility policy review, the facility failed to administer significant medications correctly when a nurse failed to correctly prime an insulin pen before administration, risking the resident not receiving a sufficient dose of the medication for 1 of 8 residents sampled for medication administration (Resident #15). The facility reported a census of 86. Findings include: Resident #15's Minimum Data Set (MDS) assessment dated [DATE] documented that the resident had intact cognition with a score of 15. The MDS included diagnoses of anemia (low blood iron), hypertension (high blood pressure), renal insufficiency (kidney failure), diabetes mellitus (diabetes), and cellulitis (skin infection) of the right lower limb. The MDS indicated Resident #15 used insulin during the lookback period.The Care Plan revised 5/8/26, documented Resident #15 required insulin therapy for diabetes. The Interventions directed staff members to administer insulin as ordered.Resident #15's May 2026 Medication Administration Record (MAR) documented they received Insulin Lispro KwikPen for the management of diabetes.On 5/13/26 at 11:21 AM, observed Staff I, Licensed Practical Nurse (LPN), pressed the administration button on an Insulin Lispro autoinjector without setting any units of insulin to waste in the autoinjector. Staff I administered the insulin to Resident #15.On 5/13/26 at 11:21 AM, Staff I stated she'd primed the insulin pen.On 5/13/26 at 11:58 AM, Staff I stated she wasn't sure if she'd primed the pen with 2 units of insulin. She confirmed staff should prime the pen with 2 units of insulin before administering the medication.On 5/18/26 at 3:13 PM, Staff H, Registered Nurse (RN), stated facility standard practice required staff to prime two units of insulin before administering the medication. She explained this ensures the resident gets the full dose of insulin and ensures the needle works correctly.On 5/20/26 at 10:30 AM, the Director of Nursing (DON) stated the proper procedure for administering insulin depended on the order. She explained autoinjector pens require that staff prime them with typically 2 units, though that varied based on the autoinjector type. Staff then waste the units, set the correct dosage, and administer the insulin. She stated this ensured the needle worked and the resident received the full dose.The Instructions for Use - Insulin Lispro document Revised July 2023 directed users to prime the pen to remove air from the needle and cartridge that collects during normal use and ensures the pen works correctly. The priming procedure listed to set the pen to 2 units of insulin, holding the pen with the needle pointing upward to collect bubbles at the tip, and push the administration button until it reads zero units while assessing to ensure insulin comes out of the needle tip.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, staff interview, and policy review, the facility failed to ensure appropriate food handling practices were followed for 2 of 2 dining rooms observed. The facility reported a census of 86. Findings include: During a continuous lunch service observation in the Assist Dining Room on 5/12/26 at 12:12 PM, Staff B, Certified Nursing Assistant, used their bare hands to touch and butter a slice of bread at the table for a resident. Once finished the resident proceeded to eat the bread. At 12:38 PM, Staff B sneezed directly into their hand and without completing any hand hygiene, provided feeding assistance to a resident. During a continuous lunch service observation in the Main Dining Room on 5/12/16 at 12:10 PM, observed Staff C, Dietary Aide, touch, cut, and prepare a fresh [NAME] with their bare hands at the table for a resident.During an interview on 5/14/26 at 4:00 PM, the Administrator acknowledged staff should not touch ready-to-eat resident food with their bare hands. During an interview on 5/20/26 at 10:30 AM, the Director of Nursing (DON) reiterated staff should not touch resident food with their bare hands. The staff should wear gloves if they need to touch resident's ready-to-eat food. The DON noted Staff B should have completed hand hygiene after they sneezed into their hands and before assisting residents. The policy Bare Hand Contact with Food and Use of Gloves, February 2016 edition, noted gloves are to be worn whenever handling food directly with their hands (handling ready-to-eat foods, anything food directly touched).The policy Handwashing, February 2016 edition, outlined hands will be washed: a. After using a handkerchief or tissue b. After handling your hair or touching your face c. After using hands to cover your mouth to cough, etc.

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a plan that describes the process for conducting QAPI and QAA activities. Based on the Provider History Report, State Agency Website, Quality Assurance and Performance Improvement Plan (QAPI), staff interview, and facility policy review, the facility failed to adequately address repeat regulatory violations in the following regulatory categories: F812, F880, F725, and F684. The facility reported a census of 86. Findings include: A review of the State Agency Website documented the following deficiencies: F684: 8/11/22, 8/28/24, 10/7/25, and again most recently with the survey ending 5/20/26. F725: 8/11/22, 2/26/24, and again with the survey ending 5/20/26. F812: 8/11/22, 8/28/24, 10/7/25, and with the survey ending 5/20/26. F880: 8/11/22, 2/26/24, 8/28/24, and again with the survey ending 5/20/26. A review of the Federal Provider History Report, printed on 5/20/26, verified the findings of the State Agency Website. In an interview on 5/20/26 at 4:05 PM the Administrator acknowledged the repeat deficiencies and stated the facility would implement a performance Improvement Plans (PIPs), to address the four repeated categories. She cited staff turnover as the cause for repeated issues.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, staff interview, and policy review, the facilty failed to complete glove change and hand hygiene during personal cares, implement Enhanced Barrier Precautions (EBP) as indicated, and proper glucometer cleaning for 3 of 7 residents reviewed for infection control (Resident #8, #11, and #15). The facility reported a census of 86. Findings include:1. Resident #8's Minimum Data Set (MDS) completed on 3/18/26 revealed a Brief Interview for Mental Status (BIMS) score of 7, indicating severe cognitive impairment. Diagnoses included Alzheimer's disease (progressive memory loss) and stroke (brain tissue damage). The MDS noted Resident #8 depended on staff for chair to bed transfers, bed mobility, personal hygiene, and toileting hygiene.On 5/12/26 at 12:45 PM observed Staff F, Hospice Certified Nursing Assistant (CNA), and Staff G, Hospice CNA, enter Resident #8's room to complete toileting cares and personal hygiene. Staff F and Staff G put gloves on, transferred Resident #8 from the wheelchair to the bed via a mechanical lift, and proceeded to complete cares. After they removed the soiled incontinence brief, Staff F held Resident #8 on their side while Staff G used wet wipes to clean Resident #8's perineal area due to visible urine and fecal residue. Staff G didn't perform hand hygiene or change gloves after completing perineal cares. Both staff members rolled Resident #8 onto their back, placed a new incontinence brief, redressed, and repositioned them. During this time, Staff G touched Resident #8's hand, head wrap, glasses, clothing, blankets, and bed remote control with the same pair of gloves worn during perineal cares. After Resident #8 voiced no further needs, both staff members removed their gloves and completed hand hygiene.On 5/14/26 at 4:00 PM Director of Nursing (DON) acknowledged staff should've completed a glove change and hand hygiene after completing perineal cares and before resuming resident cares. The DON stated that staff shouldn't wear the same pair of gloves throughout cares.The Handwashing/Hand Hygiene policy revised August 2019 instructed that all personnel shall follow the handwashing and hand hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitors. The policy directed staff to use an alcohol-based hand rub containing at least 62% alcohol or alternative soap and water for the following situations:a. Before and after direct contact with residentsb. Before moving from a contaminated body site to a clean body site during resident caresc. After handling used dressing or contaminated equipmentd. Use of gloves doesn't replace handwashing or hand hygiene, and integrating glove use along with routine hand hygiene represents the best practice for preventing healthcare-associated infections2. Resident #11's Minimum Data Set (MDS) completed on 4/7/26 revealed a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. Diagnoses included chronic obstructive pulmonary disease, dysphagia (swallowing difficulties), and stroke. The MDS documented the presence of a feeding tube due to swallowing difficulties.The Care Plan Focus initiated 4/2/26 indicated Resident #11 used tube feedings for nutrition. Interventions included Enhanced Barrier Precautions (EBP), which staff added to the Care Plan on 4/3/26.On 5/12/26 at 3:15 PM Resident #11's room lacked signage, either outside on the door or inside the room, indicating the need for staff to follow Enhanced Barrier Precautions (EBP) during cares. On 5/12/26 at 3:45 PM staff placed an EBP sign on the door.On 5/18/26 at 3:13 PM Registered Nurse (RN) Staff H explained that staff use Enhanced Barrier Precautions (EBP) as a standard when caring for residents with wounds and indwelling devices like catheters or gastric tubes (feeding tubes). Staff H noted personal protective equipment (PPE) included gloves and gowns.On 5/18/26 at 3:46 PM Staff D, Certified Medication Aide, reported Enhanced Barrier Precautions (EBP) consisted of gowns and gloves for residents with indwelling devices or wounds. Staff D stated EBP applied to all cares that involve touching the resident if a sign existed on the door, but staff don't need EBP if no sign existed on the door.On 5/20/26 at 10:30 AM the DON explained that staff should post Enhanced Barrier Precautions (EBP) warnings or signs on doors to alert staff.The Enhanced Barrier Precautions policy revised 3/28/24 directed:a. The facility will communicate with staff to ensure that staff are aware of which (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	residents require the use of EBP prior to providing high-contact care activitiesb. Staff should use EBP for the duration of the affected resident's stay in the facility or until resolution of the wound or discontinuation of the indwelling medical device that placed them at higher risk3. Resident #15's Minimum Data Set (MDS) completed on 5/11/26 revealed a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. The MDS documented the presence of an infected wound.The Care Plan Focus initiated 5/7/26 indicated Resident #15 had a skin impairment due to the presence of a right foot surgical wound. The Interventions included the use of Enhanced Barrier Precautions (EBP).The Progress Note dated 5/7/26 at 8:51 PM documented Resident #15 admitted to the facility. The note indicated Resident #15 had a wound to the right fifth toe amputated site along with a wound vac (vacuum-like medical device that uses gentle suction to remove excess fluid and bacteria).The Progress Note dated 5/7/26 at 9:05 PM documented the presence of a peripherally inserted central catheter (PICC) line in Resident #15's left arm. The note defined a PICC line as a long, thin tube inserted into an arm vein and threaded through to a large central vein near the heart, which staff use for long-term treatments like administering antibiotics.Resident #15's May 2026 Medication Administration Record (MAR) included the following medication orders:a. Cefepime HCl (antibiotic): Infuse 2 grams intravenously (IV) every 8 hours related to pyoderma gangrenosum (painful skin wounds)b. Lantus (insulin): Inject 25 units subcutaneously two times a day for type 2 diabetesc. Lispro (insulin): Inject 10 units subcutaneously before meals related to type 2 diabetesd. Lispro: Inject sliding scale insulin subcutaneously per blood sugar readings 4 times per [NAME]. Flush PICC line with 10 milliliters (ml) normal saline before and after medication administration and every 12 hours as neededOn 5/13/26 at 11:21 AM Staff I, Licensed Practical Nurse (LPN), obtained a blood sugar reading on Resident #15 as ordered. Once Staff I received results, Staff I used an alcohol swab to wipe down the glucometer (small device used to test for blood sugar). After comparing the blood sugar results to physician orders, Staff I administered the sliding scale Lispro insulin into Resident #15's abdomen area. During this process, Staff I wore gloves but didn't wear a gown as outlined per Enhanced Barrier Precautions (EBP) standards.On 5/20/26 at 10:30 AM the DON explained that staff should've followed Enhanced Barrier Precautions (EBP) procedures. The DON expected staff to wear both gloves and gowns, per EBP guidelines, during medication administrations. The DON explained that when sanitizing a glucometer after resident use, staff shouldn't do a quick wipe-down with an alcohol swab. Instead, staff should place the glucometer on a non-permeable barrier, use a Sani wipe to wipe the machine down to maintain a wet surface area, and let it sit for the recommended amount of time.The Enhanced Barrier Precautions policy revised 3/28/24 outlined the following:a. EBP refers to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and glove use during high-contact resident care activitiesb. Staff will initiate an order for EBP for residents with wounds (such as unhealed surgical wounds) or indwelling medical devices (such as central intravenous lines)c. PPE for EBP remains necessary when performing high-contact care activitiesd. Staff should use EBP for the duration of the affected resident's stay in the facility or until resolution of the wound or discontinuation of the indwelling medical device that placed them at higher risk.