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	10/07/2025

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 document review, observations, staff interview, and policy review, the facility failed to ensure food served and prepared in accordance with professional standards for food service safety. The facility reported a census of 88.Findings include: Review of August 2025 food temperature logs noted the following: 1.No breakfast temperature documentation for 21 days out of 31 2.No lunch temperature documentation for 21 days out of 31 3.No supper temperature documentation for 10 days out of 31Review of September food temperature logs noted the following: 1.No breakfast temperature documentation for 9 days out of 30 2.No lunch temperature documentation for 11 days out of 30 3.No supper temperature documentation for 21 days out of 30During a continuous lunch service observation on 10/1/25 at 11:45 AM, the following noted 1.An electrical extension cord wrapped to a bar on the service table noted with visible dried food splatter and grime 2.Top of cabinets, which were located above a food prep area, noted with a layer of visible dust 3.Staff B, Dietary employee, noted with painted artificial fingernail with 2 nails having a small [NAME] embellishment During an interview of 10/2/25 at 9:20 AM, the Certified Dietary Manager (CDM) explained food temperatures should be obtained and documented before and after each meal. The CDM acknowledged the condition of the electrical extension cord and top of the cabinets. Both of these areas are wiped down as needed and not listed cleaning checklists. The CDM confirmed dietary staff should not have artificial nails. The policy Food Preparation and Service, version 2.1 (H5MAPL0333), outlined the following: 1. Food thermometers used to check food temperatures are clean, sanitized and calibrated for accuracy 2. The following internal cooking temperatures/times for specific foods are reached to kill or sufficiently inactivate pathogenic microorganisms: a. 145 F for 15 seconds for raw eggs cooked for immediate service, fish (except as listed below), meat (except as listed below) b. 155 F for 15 seconds for ground meat (beef, pork), ground fish c. 165 F for 15 seconds for poultry, stuffed fish, meat, pork, pasta, ratites & poultry, and stuffing containing fish, meat, ratites & poultry 3. Fresh, frozen or canned fruits and vegetables are cooked to a holding temperature of 135 F. 4. Mechanically altered hot foods prepared for a modified consistency diet remain above 135 F during preparation or they are reheated to 165 F for at least 15 seconds 5. The temperatures of foods held in steam tables are monitored throughout the meal by food and nutrition services staff 6. Food and nutrition services staff keep fingernails trimmed and clean. Jewelry is worn minimally and hand jewelry (i.e., wedding ring) is covered with gloves.The policy Sanitation, version 1.1 (H5MAPL0803), outlined kitchen and dining room surfaces not in contact with food shall be cleaned on a regular schedule and frequently enough to prevent the accumulation of grime. The undated Personal Appearance Policy outlined false nails and nail polish not permitted for dietary team members.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. Based on clinical record review, policy review, and staff and resident interviews, staff failed to transfer a resident using a technique which would not place pressure on the resident's compromised left foot and failed to notify the podiatrist in a timely manner of an open area for 1 of 3 residents reviewed for skin ulcers(Resident #6). The facility reported a census of 88 residents.Findings included: The Minimum Data Set(MDS) assessment tool, dated 8/20/25, listed diagnoses for Resident #6 which included osteomyelitis(infection of the bone) of the foot, diabetes, and heart failure. The MDS stated the resident required substantial to maximal assistance with chair to bed transfers and listed her Brief Interview for Mental Status(BIMS) score as 3 out of 15, indicating severely impaired cognition. The facility policy Wound Care, revised October 2010, stated the purpose of the procedure was to provide guidelines for the care of wounds to promote healing. The policy directed staff to review the resident's care plan to assess for any special needs of the resident.A 4/15/25 Foot and Ankle Surgery Progress note stated the resident had a history of ulceration of the left hallux(the big toe, the first digit of the foot) with underlying osteomyelitis and stated the resident underwent a left hallux amputation on 4/14/25.A 4/21/25 Care Plan entry stated the resident utilized opioid medications related to toe amputation and acute pain.7/17/25 podiatry clinic visit notes stated the resident presented for a follow up of the left hallux amputation completed on 4/14/25. The report stated the resident had no open wounds at the time and directed to follow up in two months or sooner if issues arose. A 7/18/25 Care Plan entry stated the resident had actual impairment of the skin and a diabetic ulcer.A 9/5/25 Advanced Registered Nurse Practitioner(ARNP) Encounter Note stated (the facility) would carry out a culture(a procedure which determined which type of bacteria was present in a specimen) of the left plantar(referring to the underside) foot to assess for possible infection due to deterioration and malaise(a general feeling of discomfort, illness, or uneasiness whose exact cause was difficult to identify) and a significant odor in room.The September Medication Administration Record(MAR) listed a 9/6/25 order for cephalexine(an antibiotic) 500 milligrams(mg) by mouth four times daily for left foot infection. The MAR listed a discontinuation date of 9/8/25. A 9/8/25 ARNP Encounter Note stated the foot culture showed moderate growth and the resident would receive Augmentin(a medication which contained two antibiotics, used to treat bacterial infections) per the susceptibility report for a toe infection. A 9/8/25 Nurses Note listed a new order for Augmentin 875/125 mg twice daily for 10 days. A 9/10/25 SW-Skin Issues Note stated the left plantar foot wound was deteriorating and measured 1.31 centimeters(cm) x 1.42 cm x 0.3 cm(length x width x depth) and stated the wound had pale, red, watery drainage with an odor after cleansing. The facility lacked documentation of podiatrist notification of the resident's left foot open area/infection from the discovery of the wound on 9/5/25 until her podiatrist appointment on 9/17/25. A 9/17/25 podiatry clinic visit note stated the resident presented for a follow up of the left hallux amputation completed on 4/14/25 and that the resident had a new opening on the plantar aspect. The resident did not know how long it had been there. The location of the wound was the subfirst metatarsal head(referred to the base of the big toe) and it probed to the bone. The note stated she did not wear her diabetic shoes and inserts today and was unsure why and wore a protective boot. The resident would continue strict nonweightbearing. Given that the wound probed to the bone, there was a high risk for underlying osteomyelitis. The resident would undergo Magnetic Resonance Imaging (MRI, a non-invasive imaging technique that used a powerful magnetic field, radio waves, and a computer to create detailed images of the body's internal structures, especially soft tissues) and a biopsy would be considered versus further amputation.A 9/17/25 Appointment/Visit Note stated the resident had an MRI scheduled on 10/8/25.A 9/17/25 Nurses Note stated the resident returned from podiatry with a new order for non-weight bearing on the left foot. A 9/24/25 SW-Skin Issues Note stated left plantar foot wound measured 2.03 cm x 1.55 cm x 0.2 cmOn 10/1/25 at 9:41 a.m., Staff C Registered Nurse(RN)/Wound Nurse measured a red open wound on the resident's left plantar foot as 3.5 cm x 2.0 cm(length x (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	width). Staff C did not measure the depth of the wound but stated it was approximately 0.3 cm deep.On 10/2/25 at 2:01 p.m., Resident #6 stated she just had a shower and did not wear shoes but was bare footed when she transferred. She stated she did not wear her shoe unless someone made her. On 10/2/25 at 2:04 p.m., Staff E Certified Nursing Assistant(CNA) stated she assisted the resident in the shower today. She at first stated that the resident wore her post-op shoe during the transfer into the shower chair but then stated that the shoe was in the laundry so she did not wear it and instead wore her blue gripper socks. Staff E stated when the resident stood up, she placed pressure on both feet. On 10/6/25 at 10:47 a.m., Staff F CNA stated she assisted the resident out of bed this morning. She stated she stood and pivoted during the transfer and was flat footed with both feet. She stated the resident did not place pressure on only her heel during the transfer. On 10/6/25 at 11:01 a.m., Staff G CNA stated when they assisted the resident to transfer, she stood and pivoted. She stated staff instructed the resident to just use the right foot but she did place pressure on the left. She stated the resident was not able to avoid placing pressure on her left toe. On 10/6/25 at 11:57 a.m., Staff D Wound Nurse stated the reason she did not notify the podiatrist of the change in the resident's wound(on 9/5/25) was because she had an upcoming appointment(on 9/17/25). She stated during her last appointment, she changed to non-weight bearing.On 10/6/25 at 12:12 p.m., Staff H stated she assisted the resident out of bed on 10/1/25 or 10/2/25. She stated when the resident transferred, she was flat footed and didn't use her heel only. Staff H stated she did not know the resident was to only place pressure on her heel during transfers. On 10/6/25 at 12:39 p.m., the Director of Nursing(DON) stated if there was a concern with a wound, they tried to update the podiatrist as soon as possible, within 24 hours. She stated the resident was a 2 assist with no weight bearing to the lower left extremity. She stated the facility just updated her to be a mechanical lift transfer. When queried as to why this occurred just this morning, the DON stated it was her understanding that the resident completed transfers fairly well before this. She stated if the resident was not able to maintain non-weight bearing during a transfer, they would come up with a different plan. On 10/7/25 at 8:50 a.m., Staff C Podiatrist stated if the resident was not wearing her post-operative shoe or if she had been bearing weight on the left foot since 9/17/25, this could make the ulceration worse. He stated if the resident was unable to maintain non-weightbearing on the left, he expected the facility to make a different plan sooner than after a few weeks. The facility lacked documentation they modified the resident's transfer status to a mechanical lift prior to 10/6/25 in order to maintain non-weight bearing status.

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. Based on electronic health record (EHR) review, observations, resident and staff interviews, the facility failed to ensure residents were aware of and offered alternative menu options for 2 of 3 residents reviewed for food (Residents #4 and #79). The facility reported a census of 88.Findings include: 1. The Minimum Data Set (MDS) Assessment, completed 7/29/25, revealed Resident #4 with a Brief Interview for Metal Status (BIMS) score of 12, indicating moderately impaired cognitive status. Diagnoses include chronic obstructive pulmonary disease (COPD), chronic pain, diabetes, hemiplegia/hemiparesis, malnutrition, and peripheral vascular/arterial disease. The MDS indicated Resident #4 with a physician-prescribed weight loss regimen which resulted in a significant weight loss within the past six months. The Care Plan revised on 8/6/25 indicated Resident #4 at risk for altered nutrition status related to diabetes, COPD, and advanced age. The Care Plan noted the presence of right above the knee amputation surgical incision with dehiscence and the decision for palliative care. Interventions included to offer meal or snack alternatives as needed, provide meals that are within the diet, and to review the diet routinely by the dietitian/dietary manager. Physician Orders, obtained 10/2/25, listed a diet of small portions with regular textures and thin liquids. The Progress Note dated 9/4/25 at 6:52 PM documented Resident #4 disliked the facility food although trying to consume three meals daily. The Progress Note dated 8/7/25 at 11:48 AM, the RD documented nutritional supplement program had been started due to variable intake and increased nutrient needs related to surgical wound healing. During an interview on 9/29/25 at 1:30 PM, Resident #4 reported they prefer to eat in their room and does not go out to the dining room. The resident indicated they were not aware of how to order alternative menu items if they did not like what was offered. During an interview on 10/1/25 at 12:00 PM, Staff A, Dietary Services Assistant Manager, explained menus are reviewed with residents the day prior by either themselves or the dietary manager. Specific menu selections determined at this time. If a resident received a room tray and does not like what was served, the resident would need to inform one of the Certified Nurse Aide (CNA) who would inform kitchen staff of the alternative item. During an interview on 10/1/25 at 1:30 PM, Resident #4 stated a staff member had not reviewed the day's lunch menu with them prior to the meal. Resident #4 reported they were aware of alternative menu items but unable to recall what's available or where to go for these items. Resident #4 reported the lunch offered this day was so-so. 2. The MDS Assessment, completed 9/5/25, revealed Resident #79 with a BIMS score of 13 indicating intact cognition. Diagnoses include diabetes, hyperkalemia (high blood potassium levels), renal insufficiency/renal failure/end stage renal disease, and sarcopenia (loss of muscle mass, strength, and function). The Care Plan revised on 8/1/25 indicated Resident #79 at risk for altered nutrition status related to advanced age, chronic kidney disease, diabetes, and hyperkalemia. Interventions included to review the diet routinely by the dietitian/dietary manager, to provide meal that are within the diet, and to encourage nutrient-dense intake and offer meal or snack alternatives as needed. During an interview on 9/29/25 at 12:30 PM, Resident #79 reported they prefer to eat in their room & does not go out to the dining room. The resident indicated they are not are able to get alternative menu items. During an interview and observation on 10/1/25 at 1:15 PM, Resident #79 stated a staff member had not reviewed the day's lunch menu with them prior to the meal. The lunch offered was good today but that is not always the case. The lunch tray ticket was still present and noted to have a list of alternative menu items. Resident #79 was not aware of this and explained the print was too small for them to see. During an interview on 10/2/25 at 9:20 AM, the Certified Dietary Manager (CDM) explained they or the assistant dietary manager will visit residents daily to obtain menu selections. The CDM acknowledged they had not visited Resident #79 this week for menu selections. The CDM noted they may not get to Resident #4 every day for menu selections. A new dietary menu system was recently installed at the facility. The CDM reported food preferences do not print on (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	individual tray tickets. Food preferences are available within the system but staff would need to log into the program to obtain. With the new system, the CDM noted residents may not be fully aware alternative menu items print at the bottom of tray tickets.