DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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 _____	C 10/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKRIDGE SPECIALTY CARE	5800 NE 12TH AVENUE PLEASANT HILL, IA 50327

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS Correction Date 11-01-2021 The following deficiencies relate to an investigation of complaints 96502-C, 97394-C, 98200-C, 98303-C, 98763-C, 99028-C, 99255-C, 99263-C, 99411-C, 99532-C and facility reported incident 99423-I conducted August 24, 2021 to October 6, 2021. See Code of Federal Regulations (42CFR) Part 483, Subpart B-C.	F 000		
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observation and resident and staff interview, the facility failed to accommodate residents' needs related to meal tray service for 6 of 8 residents reviewed (Resident #4, #7, #14, #20, #21 and #26). The facility reported a census of 84 residents. Findings include: 1. During an interview on 9/2/21 at 10:35 a.m., Resident #7 verified staff served her breakfast meal on a Styrofoam plate with plastic utensils, even though she required a lip plate in order to feed herself independently.	F 558		

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

Administrator 11-01-2021

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.

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 _____	C 10/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKRIDGE SPECIALTY CARE	5800 NE 12TH AVENUE PLEASANT HILL, IA 50327

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 558	Continued From page 1 2. An observation on 9/7/21 at 3:08 p.m., revealed Resident #26's lunch tray remained in her room. The resident stated she had asked staff to remove the tray on 2 separate occasions without success and reported it bothered her. Further observation at that time revealed Resident #20's room tray remained on the resident's bedside table without the resident present. In addition, Resident #21 remained on their beside table still fully covered and not eaten as the resident slept in the bed. 3. An observation on 9/7/21 at 3:30 p.m., revealed Resident #14's remained on her bedside stand. 4. During an interview on 9/23/21 at 10:44 a.m., Resident #4 confirmed his room tray from supper remained in his room many times until the following morning when facility staff brought him his breakfast tray. 5. During an interview 9/7/21 at 3:30 p.m., Staff D, Registered Nurse (RN) stated the facility had no policy for tray removal, but added staff should have removed them upon completion of the meal.	F 558		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical,	F 580		

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 _____	C 10/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKRIDGE SPECIALTY CARE	5800 NE 12TH AVENUE PLEASANT HILL, IA 50327

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 580	Continued From page 2	F 580		

mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications);
(C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or
(D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii).
(ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician.
(iii) The facility must also promptly notify the resident and the resident representative, if any, when there is-
(A) A change in room or roommate assignment as specified in §483.10(e)(6); or
(B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section.
(iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s).

§483.10(g)(15)
Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9).

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 _____	C 10/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKRIDGE SPECIALTY CARE	5800 NE 12TH AVENUE PLEASANT HILL, IA 50327

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 580	Continued From page 3 This REQUIREMENT is not met as evidenced by: Based on clinical record review and family and staff interview, the facility staff failed to promptly notify 1 of 4 residents' (Resident # 3) families of a change in condition that resulted in a visit to the Emergency Room (ER). The facility identified a census of 84 residents. Findings include: 1. A Minimum Data Set (MDS) assessment dated 2/26/21 documented Resident #3 had diagnosis that included diabetes mellitus (DM), non-Alzheimer's dementia, muscle weakness and morbid obesity. The assessment documented the resident had a Brief Interview for Mental Status (BIMS) score of 7 out of a possible 15 (severe cognitive impairment) with fluctuating inattention and disorganized thinking. The MDS also documented the resident required extensive assistance of two staff for bed mobility and transfers and did not walk (non-ambulatory). A Care Plan documented the resident as at risk for falls (dated 1/15/20) and directed staff to transfer Resident #3 with an EZ stand lift device and assist of 2 staff (initiated 1/8/21 and revised 2/1/21). The Care Plan also documented the resident utilized a wheel chair for mobility (dated 1/28/20). An Incident Report dated 5/10/21 at 7:30 a.m., included the following documentation: Resident found face down in his room next to the wheel chair and bed, lethargic, and with a blood pressure of 97/61. Staff documented the resident felt cold and clammy with a blood sugar of 110.	F 580		

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 _____	C 10/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKRIDGE SPECIALTY CARE	5800 NE 12TH AVENUE PLEASANT HILL, IA 50327

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 580	Continued From page 4 The resident moaned in pain when moved or touched. Staff found a gash on the resident's right knee that measured 1.8 centimeters (cm's) x (by) 0.4 cm, an open area on his right hand that measured 1.7 cm x 0.6 cm, and a 3rd area on his left hand that measured 2.2 cm x 0.7 cm. Staff noted the resident's wheel chair brakes unlocked and noted he wore gripper socks. Facility staff sent the resident to the Emergency Room (ER) and the report documented staff notified family on 5/11/21 at 6:47 a.m. A hospital Discharge Face Sheet documented Resident #3 arrived at an ER on 5/10/21 at 1:27 p.m. related to a fall that resulted in lacerations. During an interview on 9/8/21 at 1:48 p.m. a family member described the resident's bruising following the fall as red, purple, and black areas that extended up and down both arms. The family member reported they brought their concerns to the Administrator at the time that conducted an internal investigation and confirmed staff failed to notify family. The family member voiced frustration related to this failure, because staff also sent the resident to the ER and, because family did not know, the resident sat in the ER for 8 hours by himself and the family never knew he was there. The family added they did not know the resident fell and went to ER until 3 days later when they came to visit him at the facility and observed all of his injuries. The family member further described this situation as frustrating. During an interview 9/28/21 at 4:10 p.m. a separate family member confirmed staff failed to notify her of the fall that occurred on Monday, 5/10/21 and stated on Thursday, 5/13/21 she visited the resident at the facility and "he was all	F 580		

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 _____	C 10/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKRIDGE SPECIALTY CARE	5800 NE 12TH AVENUE PLEASANT HILL, IA 50327

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 580	Continued From page 5 bruised up." The family member then asked what happened and the Administrator at the time said he fell to the floor "face first." The Administrator at the time "apologized all over the place" and said the facility staff accidentally called the wrong person. During an interview 9/29/21 at 12 p.m., Staff I, Registered Nurse (RN) confirmed the charge nurse at the time of the fall had been an agency nurse who no longer worked at the facility and she called another resident's family member to report the fall with injury and failed to notify the family of this resident.	F 580		
F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly,	F 584		

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 _____	C 10/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKRIDGE SPECIALTY CARE	5800 NE 12TH AVENUE PLEASANT HILL, IA 50327

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 584	Continued From page 6 and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interview, and facility policy review, the facility failed to assure 5 of 6 residents reviewed resided in a clean, sanitary and homelike environment (Resident #1, #7, #9, #11 and #14) The facility identified a census of 84 residents. Findings include: An observation 9/2/21 at 10:06 a.m. revealed a build up of dust, dirt and debris along the wall and baseboard under the head of the bed for Resident # 7. During an interview at the same time the resident confirmed the staff failed to have cleaned her room on a regular basis. An observation 9/2/21 at 10:35 a.m. revealed the bottom trim piece on the window of Resident #7 as removed. During an interview at the same	F 584		

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 _____	C 10/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKRIDGE SPECIALTY CARE	5800 NE 12TH AVENUE PLEASANT HILL, IA 50327

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 584	Continued From page 7	F 584		

time the resident stated the trim had been removed for a long time and she preferred the trim to have been in place.

An observation 9/2/21 at 11:22 a.m. revealed a build up of what appeared to have been dried food and drink along the front support bar located between the two (2) front wheels of the Broda chair for Resident #9.

An observation 9/7/21 at 3 p.m. revealed the above stated as still present on the Broda chair.

An observation 9/1/21 at 10:05 a.m. revealed two(2) holes in the wall behind the easy chair of Resident #14 that were covered with brown cardboard and secure to the wall with blue tape. The resident stated the holes had been there since she moved into the facility seven (7) years ago and her daughter and grandson placed the card board and tape. The resident confirmed the facility had been aware she wanted the holes repaired appropriately. This observation also revealed a build up of a brown substance, dust, dirt and debris on the resident's floor in front of her recliner and beside her bed.

An observation 9/2/21 at 9:41 a.m. revealed the trim along the bottom edge of the window in the room of Resident #11 was absent.

During an interview 9/2/21 at 2:30 p.m., Staff A, housekeeping reported she was the only housekeeper at the facility on this day. The staff member confirmed they only had two (2) housekeepers on staff, but they were supposed to have three (3) on staff everyday during the week and 2 on the weekends. She added they had not had that for 2 weeks, and verified the

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 _____	C 10/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKRIDGE SPECIALTY CARE	5800 NE 12TH AVENUE PLEASANT HILL, IA 50327

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 584	Continued From page 8 rooms were not clean. Review of an un-named and undated form revealed the following directives for housekeeping staff members: Additional weekly housekeeping duties: Resident rooms and day rooms: a. Monday - clean under dressers and nightstands. b. Tuesday - clean high dust, bedrails, disinfect beds and bathroom vents. c. Wednesday - dust furniture, clean windows and clean televisions. d. Thursday - clean walls and mopboards. e. Friday - clean trash cans and disinfect. During a subsequent interview with Staff A on 9/3/21 at 8 a.m., she verified the above documented housekeeping tasks had been assigned in addition to the facility's daily cleaning schedule of the common areas, and resident rooms (which included the entire room and bathroom). The staff member also verified she had been the only staff that worked on this date and had been unable to accomplish all of the assigned tasks. During an interview 9/9/21 at 3:41 p.m., Resident #1 stated when she resided at the facility, she contracted COVID-19 and the facility staff moved her to the isolation area. She reported facility staff rarely, if ever, cleaned her room. The resident knew the facility staff failed to clean her room, because when she went to the bathroom she lost pieces of her skin on the way and the pieces remained on the floor and not cleaned or removed.	F 584		

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 _____	C 10/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKRIDGE SPECIALTY CARE	5800 NE 12TH AVENUE PLEASANT HILL, IA 50327

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 609	Continued From page 9	F 609		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on clinical record review, staff and resident interview and facility policy review, the facility failed to report an injury of unknown origin to the Department of Inspections and Appeals for one resident. (Resident #13) The facility identified a census of 84 residents.	F 609		

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 _____	C 10/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKRIDGE SPECIALTY CARE	5800 NE 12TH AVENUE PLEASANT HILL, IA 50327

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 609	Continued From page 10 Findings include: A Minimum Data Set (MDS) assessment form dated 3/5/21 documented Resident #13 had diagnoses that included rheumatoid arthritis, repeated falls, osteoarthritis, muscle weakness, difficulty walking, lack of coordination, scoliosis and low back pain. The assessment documented the Resident with a Brief Interview for Mental Status (BIMS) score of 10 of a possible 15 (moderately impaired cognition). The MDS also documented the resident did not walk and required extensive assist of two (2) staff with bed mobility, transfers, and toilet use. . A Care Plan addressed the following Focus areas as dated: I had a history of falling (initiated 3/9/21) and I had a potential/actual impaired to my skin integrity. I had been at risk for pressure related areas and I had a history of skin tears (initiated 7/23/21 and revised 8/23/21). The interventions included the following as dated: a. Staff assist for all transfers (initiated and revised 3/9/21). b. Staff to provide assistance with routine repositioning, with cares, and as needed (PRN) (initiated 8/23/21). A Skin Evaluation: Non-Pressure form dated 3/5/21 at 1:44 p.m. included the following documentation: Left neck - Large 5.0 centimeter (cm) by (x) 6.0 cm ecchymosis (bruised) area noted with a small area in the center which appeared to have been from a central line that contained dried serosangineous drainage.	F 609		

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 _____	C 10/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKRIDGE SPECIALTY CARE	5800 NE 12TH AVENUE PLEASANT HILL, IA 50327

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 609	Continued From page 11 During an interview 9/1/21 at 4:45 p.m. the Senor Director of Nursing (DON) from a sister facility confirmed there had been no further assessment or intervention for the bruise along the left side of the resident's neck as documented above. According to an email 10/5/21 at 3:02 p.m., the current Administrator documented this incident occurred prior to the current Director of Nursing's and her start date. The Administrator confirmed according to the Department of Inspections and Appeals (DIA) website her predecessors failed to report the bruise to the Iowa Department of Inspections and Appeals.	F 609		
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by:	F 610		

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 _____	C 10/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKRIDGE SPECIALTY CARE	5800 NE 12TH AVENUE PLEASANT HILL, IA 50327

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 610	Continued From page 12 Based on record review, staff interview and facility policy review the facility failed investigate an injury of unknown origin (Resident #13) The facility identified a census of 84 residents. Findings include: A Minimum Data Set (MDS) assessment form dated 3/5/21 documented Resident #13 had diagnosis that included rheumatoid arthritis, repeated falls, osteoarthritis, muscle weakness, difficulty walking, lack of coordination, scoliosis and low back pain. The assessment documented the Resident with a Brief Interview for Mental Status (BIMS) score of 10 out of 15 (moderately impaired cognition), required extensive assistance of two (2) staff members with bed mobility, transfers and toilet use and as non-ambulatory. A Care Plan addressed the following Focus areas as dated: I had a history of falling (initiated 3/9/21) and I had a potential/actual impaired to my skin integrity. I had been at risk for pressure related areas and I had a history of skin tears. (initiated 7/23/21 and revised 8/23/21). The interventions included the following as dated: a. Staff assisted me for all transfers. (initiated and revised 3/9/21). b. Staff to have provided me with assistance with routine repositioning, with cares and as needed (PRN). (initiated 8/23/21). A Skin Evaluation: Non-Pressure form dated 3/5/21 at 1:44 p.m. included the following documentation: Left neck - Large 5.0 centimeter (cm) by (x) 6.0	F 610		

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 _____	C 10/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKRIDGE SPECIALTY CARE	5800 NE 12TH AVENUE PLEASANT HILL, IA 50327

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 610	Continued From page 13 cm eccymosis (bruised) area noted. Small area in the center which appeared to have been from a central line had dried serosanginous drainage. During an interview 9/1/21 at 4:45 p.m. a RN, Senior Director of Nursing (DON) from a sister facility confirmed there had been no further assessment, intervention, or investigation for the bruise that ran along the left side of the resident's neck as stated above. According to an email 10/5/21 at 3:02 p.m., the current Administrator documented this incident occurred prior to her and the current Director of Nursing's start date. The Administrator confirmed according to the Department of Inspections and Appeals (DIA) website her predecessors failed to have reported the bruise.	F 610		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident	F 657		

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 _____	C 10/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKRIDGE SPECIALTY CARE	5800 NE 12TH AVENUE PLEASANT HILL, IA 50327

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 14 and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on clinical record review and staff interview, the facility failed to update and manage resident care plans for three (3) residents reviewed. (Resident #2, #7 and #8) The facility identified a census of 84 residents. Findings include: 1. A Minimum Data Set (MDS) assessment form dated 12/18/20 documented Resident #2 had diagnosis that included hemiplegia, cerebral infarct due to a thrombosis, type 2 diabetes mellitus (DM) muscle weakness and a need for assistance with personal cares. The assessment documented the resident scored 11 of 15 points possible on the Brief Interview for Mental Status (BIMS) test which meant the resident demonstrated moderately impaired cognitive abilities. The MDS also documented the resident could not walk and remained totally dependent on two (2) staff for surface-to-surface transfers and required extensive assist of 2 staff for bed mobility and toilet use. The MDS revealed the resident had no skin conditions. A Pressure Injury Evaluation form dated 12/24/21 at 11:51 a.m. documented the resident with a new	F 657		

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 _____	C 10/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKRIDGE SPECIALTY CARE	5800 NE 12TH AVENUE PLEASANT HILL, IA 50327

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 15	F 657		

onset stage II pressure area on his coccyx that measured 1.8 centimeters (cm) x 2.4 cm x 0.1 cm deep with no drainage, tunneling or undermining, the wound bed contained pink/red granulation tissue and the surrounding skin had been normal.

According to hospital records the resident had been admitted to the hospital on 12/28/20 and discharged back to the facility on 1/6/21. Photo images scanned on 12/28/20 at 6:56 p.m. revealed a large open area on the residents coccyx (not measured) with bruising and abrasions around the outer limits of the resident's buttocks at the upper thigh region at the lower gluteal crease in an oval/round dimension.

Discharge orders from the hospital dated 1/6/21 directed the facility staff to crust the resident's buttock with stoma powder, Calmoseptine and then another layer of stoma powder every day (QD).

The resident's Care Plan failed to address any skin issues.

2. An MDS assessment form dated 8/4/21 documented Resident #7 had diagnosis that included diabetes mellitus (DM), anxiety, chronic obstructive pulmonary disease (COPD) and cerebellar ataxia. The assessment documented the resident with a Brief Interview for Mental Status (BIMS) score of 12 out of 15 (moderately impaired cognitive skills) and indicated the resident required limited assistance of 1 staff with eating.

A Care Plan with a focus are that included a regular diet with thin liquids, and difficulty

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 _____	C 10/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKRIDGE SPECIALTY CARE	5800 NE 12TH AVENUE PLEASANT HILL, IA 50327

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 16 chewing, swallowing and feeding myself. Resident kept food room which they bought and this is what she preferred (revised 8/4/21). The care plan failed to include an intervention that directed staff to provide a lip plate. During an interview 9/2/21 at 10:35 a.m. the resident confirmed staff served her breakfast meal on a Styrofoam plate and plastic utensils; this had not worked for her because she required a lip plate to enable her to eat independently. 3. An MDS assessment form dated 4/16 showed Resident #8 had diagnoses that included: multiple sclerosis, morbid obesity, muscle weakness, abnormal posture, arthritis, and osteoporosis. The assessment documented the resident had a BIMS score of 12, required extensive assistance of 2 staff with transfers, could not walk, and did not experience any falls. A Care Plan initiated 8/4/15 and revised 7/1/16, documented the resident as at risk for falls due to poor balance and a history of falls. The Care Plan directed staff to transfer the resident with 2 staff assist and an assistive device (initiated 2/16/18 and revised 11/24/20). An Incident Report form dated 5/20/21 at 11 p.m. as the CNA transferred the resident by herself to a recliner via a lift device, the resident felt tired and started to go down, so the CNA lowered her to the floor. The resident had been alert and oriented times (x) 3 and received passive range of motion to all extremities without any complaints of pain or injury noted.	F 657		
F 658 SS=E	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i)	F 658		

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 _____	C 10/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKRIDGE SPECIALTY CARE	5800 NE 12TH AVENUE PLEASANT HILL, IA 50327

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 658	Continued From page 17 §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, clinical record review and staff and a Pharmacist interview and facility policy review, the facility failed to follow physician's orders for 4 of 6 residents reviewed (Residents #1, #2, #14, and #24), and failed to administer medications according to accepted professional standards for 1 of 3 residents reviewed (Residents #7, #12, #14 and #18). The facility identified a census of 84 residents. Findings include: A form without a name or date identified the facility's medication (med) administration times as follows: a. Morning medication pass from 7 a.m. to 9 a.m. - Staff may start administration at 6 a.m. and continue until 10 a.m. b. Noon med pass from 11 a.m. to 1 p.m. - Staff may start administration at 10 a.m. and continue until 2 p.m. c. Evening med pass from 4 p.m. to until 6 p.m. - Staff may start administration at 3 p.m. and continue until 7 p.m. d. Hour of Sleep med pass from 8 p.m. until 10 p.m. - Staff may start administration at 7 p.m. and continue until 11 p.m. 1. A Minimum Data Set (MDS) assessment form dated 2/2/21 indicated Resident #1 had diagnosis	F 658		

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 _____	C 10/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKRIDGE SPECIALTY CARE	5800 NE 12TH AVENUE PLEASANT HILL, IA 50327

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 658	Continued From page 18	F 658		

the included: diabetes mellitus (DM), thyroid disorder, morbid obesity, muscle weakness, acute kidney failure, and moderate and protein-calorie malnutrition. The assessment indicated the resident had a BIMS score of 15 out of 15 (intact cognitive abilities), did not walk, and required extensive assist of 2 staff with bed mobility, transfers and toilet use. The assessment documented the resident had a surgical wound and was at risk for pressure sores, but had no current pressure sores. The MDS revealed staff did not provide a turning and repositioning program for Resident #1.

An MDS assessment form dated 2/17/21 did not contain a BIMS score, but documented the resident demonstrated modified independence with difficulty in new situations only. The MDS assessment documented the resident had three (3) stage III pressure ulcers (Stage III described as full thickness tissue loss; subcutaneous fat may have been visible but bone, tendon or muscle not been exposed. Slough may have been present but had not obscured the depth of the tissue loss and may have included undermining and tunneling.)

A Care Plan created on 1/26/21 documented the resident had a pressure area related injury to her skin and a focus area of a potential for skin integrity impairment related to impaired mobility, incontinence of bowel and bladder, presence of a JP drain (Jackson Pratt drain for wounds) and a rash to her bilateral upper and lower extremities initiated 2/5/21 and revised 2/26/21. The Interventions/Tasks included the following as dated:

a. Monitor, remind, and assist to turn and

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 _____	C 10/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKRIDGE SPECIALTY CARE	5800 NE 12TH AVENUE PLEASANT HILL, IA 50327

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 658	Continued From page 19 reposition frequently (initiated 1/26/21 and revised 2/26/21) b. Follow facility protocols for treatment of injury (initiated 2/5/21 and revised 2/26/21) c. Monitor for and document locations, size and treatment of the skin injury. Report abnormalities, failure to heal, signs and symptoms of infection, and maceration, etc to the physician. (initiated 2/5/21 and revised 2/26/21) A Treatment Administration Record (TAR) form dated 2/1/21 through 2/28/21 documented the resident had a Triad Hydrophilic Wound Dress Paste (wound dressings) applied to the right and left buttocks and the coccyx topically every shift for wound care started 2/5/21 at 10 p.m. and discontinued (dc'd) 2/26/21 at 10:44 a.m. The facility staff failed to administer the treatment on the day shift on 2/7, 2/8, 2/12 through 2/14, on the p.m. shift 2/6, /2/8, and 2/15 and on the night shift 2/8, 2/15, 2/17, through 2/19. The TAR form also directed the staff to cleanse the resident's right lower left with wound cleanser, followed by an application of TAO (triple antibiotic ointment) and cover with gauze every day shift for wound care started on 2/6/21 at 6 a.m. and discontinued on 2/26/21 at 10:44 a.m. The facility staff failed to provide the treatment 2/7/21 and 2/12 thru 2/14. During an interview 9/9/21 at 3:41 p.m. the resident confirmed the pressure ulcers first presented themselves in the hospital but were "little." When she arrived at the facility, the ulcers increased in size and staff failed to provide treatments per physician's order to the pressure ulcers and her rashes. This caused them to increase in size. 3. A Minimum Data Set (MDS) assessment form	F 658		

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 _____	C 10/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKRIDGE SPECIALTY CARE	5800 NE 12TH AVENUE PLEASANT HILL, IA 50327

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 658	Continued From page 20 dated 12/18/20 documented Resident #2 had diagnosis that included hemiplegia, cerebral infarct due to a thrombosis, type 2 diabetes mellitus (DM) muscle weakness and a need for assistance with personal cares. The assessment documented the resident with a Brief Interview for Mental Status (BIMS) score of 11 out of 15 (moderately impaired cognition), dependent on two (2) staff with transfers, extensive assistance of 2 staff with bed mobility and toilet use, non-ambulatory and with no skin conditions. A Pressure Injury Evaluation form dated 12/24/21 at 11:51 a.m. documented the resident with a new onset stage II pressure area on his coccyx that measured 1.8 centimeters (cm) x 2.4 cm x 0.1 cm deep with no drainage, tunneling or undermining, the wound bed contained pink/red granulation tissue and the surrounding skin had been normal. According to hospital records the resident had been admitted to the hospital on 12/28/20 and discharged back to the facility on 1/6/21. Photo images scanned on 12/28/20 at 6:56 p.m. revealed a large open area on the residents coccyx (not measured) with bruising and abrasions around the outer limits of the resident's buttocks at the upper thigh region at the lower gluteal crease in an oval/round dimension. Discharge orders from the hospital dated 1/6/21 directed the facility staff to crust the resident's buttock with stoma powder then Calmoseptine and another layer of stoma powder every day (QD). Review of the resident's 1/1/21 - 1/31/21 Treatment Administration Record (TAR) revealed no documentation/administration of this physician's order.	F 658		

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 _____	C 10/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKRIDGE SPECIALTY CARE	5800 NE 12TH AVENUE PLEASANT HILL, IA 50327

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 658	Continued From page 21 A TAR form dated 2/1/21 - 2/28/21 documented the resident received a physician's order for Calmoseptine Ointment 0.44-20.6% (Menthol-Zinc Oxide) apply to the right buttock topically every day and evening shift for skin management (dated 2/12/21 and discontinued on 2/25/21). The facility staff failed to provide the treatment on 2/16 through 2/18/21 on the PM (evening) shift. A TAR form dated 3/1/21 - 3/31/21 documented the resident received a physician's order for Calmoseptine Ointment 0.44-20.6% (Menthol-Zinc Oxide) apply to buttocks topically every shift for prevention until healed. The facility staff failed provide the treatment on 3/29 and 3/30 on the day shift and 3/27 and 3/28 on the PM shift. The TAR also indicated the resident received a physician's order on 3/18/21 through 4/16/21 for staff to cleanse the buttock and post left thigh with wound cleanser and apply Desitin cream 13% (zinc oxide) topically every shift for wounds. The facility staff failed provide the treatment on 3/29 on the day shift and 3/27 and 3/28 on the PM shift. A TAR form dated 4/1/21 - 4/30/21 documented the resident received a physician's order on 4/17/21 through 7/19/21 for A&D ointment (Vitamins A & D) - apply to the right and left buttocks topically two times a day (BID) for prevention. The facility staff failed to provide the treatment at the hour of sleep (HS) on 4/18 and 4/30. The TAR also indicated the resident received a physician's order for Calmoseptine Ointment 0.44-20.6% (Menthol-Zinc Oxide) apply to buttocks topically every shift for prevention until healed (dated 3/26/21 and discontinued on	F 658		

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 _____	C 10/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKRIDGE SPECIALTY CARE	5800 NE 12TH AVENUE PLEASANT HILL, IA 50327

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 658	Continued From page 22	F 658		

4/16/21). The facility staff failed to provide the treatment on the day shift, 4/4, 4/5 and 4/8 and on the PM shift 4/1, 4/5 thru 4/7 and 4/10. The TAR also indicated the resident received a physician's order that directed staff on 3/18/21 thru 4/16/21 to cleanse the buttock and post left thigh with wound cleanser and apply Desitin cream 13% (zinc oxide) topically every shift for wounds. The facility staff failed to administer the treatment on the day shift 4/4, 4/5 and 4/8, on the PM shift 4/1, 4/5 thru 4/7 and 4/9.

A TAR form dated 5/1/21 - 5/31/21 documented the resident received a physician's order on 4/17/21 thru 7/19/21 for A&D ointment (Vitamins A & D) - apply to the right and left buttocks topically two times a day (BID) for prevention. The facility staff failed to administer the treatment on the day shift 5/1, 5/3, 5/4, 5/29 and 5/31, on the HS shift 5/4, 5/12 and 5/24.

A TAR form dated 6/1/21 - 6/30/21 documented the resident received a physician's order on 4/17/21 through 7/19/21 for A&D ointment (Vitamins A & D) - apply to the right and left buttocks topically two times a day (BID) for prevention. The facility staff failed to administer the treatment on the days shift 6/12, 6/14 and 6/22 through 6/24, on the HS shift 6/2, 6/7 through 6/9, 6/24 and 6/28 through 6/30.

A TAR form dated 7/1/21 - 7/31/21 documented the resident received a physician's order on 4/17/21 through 7/19/21 for A&D ointment (Vitamins A & D), apply to the right and left buttocks topically two times a day (BID) for prevention. The facility staff failed to administer the treatment on the day shift 7/5, 7/6, 7/10 through 7/12, 7/17 and 7/18 and on the HS shift

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 _____	C 10/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKRIDGE SPECIALTY CARE	5800 NE 12TH AVENUE PLEASANT HILL, IA 50327

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 658	Continued From page 23 7/18 and 7/19. 4. An MDS assessment form dated 9/21/21 documented Resident #14 had diagnosis that included, cellulitis of the left lower limb, type II DM with a foot ulcer and peripheral vascular disease (PVD). The assessment documented the resident as at risk for pressure ulcers and with a diabetic foot ulcer. A TAR form dated 8/1/21 - 8/31/21 documented the resident received a physician's order on 8/18/21 for Iodosorb Gel 0.9% (Cadexomer Iodine) to apply to the resident's left foot after cleansing the area with wound cleanser on the day shift every other day and then cover with a Band-Aid. The resident also received a physician's order for an application of a Prevalon boot to her left lower extremity for pressure ulcer prevention every shift for healing. An observation 9/1/21 at 10:05 a.m. revealed Resident #14 as she sat in her recliner in her room with her feet positioned on a dirty floor as noted by a build-up of a brown substance, dust, dirt, and debris without a Band-Aid covering her ulcered area and/or with the Prevalon boot in place. The open area on the bottom of her left foot had been approximately a quarter sized calloused area with an approximately pea sized open are in the middle of the callous with no drainage or redness. 5. A Minimum Data Set (MDS) assessment form dated 7/7/21 documented Resident #24 had diagnosis that included anxiety and adult failure to thrive. The assessment documented the resident with a Brief Interview for Mental Status (BIMS) score of 14 out of 15 (cognitively intact)	F 658		

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 _____	C 10/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKRIDGE SPECIALTY CARE	5800 NE 12TH AVENUE PLEASANT HILL, IA 50327

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 658	Continued From page 24 A Medication Error form dated 7/6/21 at 12:01 p.m. included the following documentation: During the morning medication pass the resident received the wrong medication. The assigned nurse to the hallway accidentally administered a resident's medications with a similar name as this resident. Resident took all of the medication except one (1) pill before a realization that the medications she took were not taken prior. The resident then called the nurse for a list of her medications. The resident stated, I noticed a pill in my medications cup that I was not familiar with so I called for the nurse for an explanation of the medications I was supposed to take. A Progress Notes entry dated 7/6/21 at 5:27 p.m. included the following documentation: Resident observed as she sat in a chair and visited with family. Alert and oriented times (x) 3, reported dizziness while she stood, pupils equal and reactive to light and accommodation (PERRLA), mucous membranes moist and pink, lung sounds clear x 5, regular rate and rhythm of her heart, bowel sounds x 4, denied pain with urination or with bowel movements, 1 + edema observed to her bilateral lower extremities. Staff left the resident up to have visited with her family. A Progress Notes entry dated 7/7/21 at 5:20 p.m. included the following documentation: During the morning medication pass the resident received the wrong medications. The assigned nurse to hallway accidentally administered another resident's medication with a similar name to the resident. The resident took all of the	F 658		

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 _____	C 10/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKRIDGE SPECIALTY CARE	5800 NE 12TH AVENUE PLEASANT HILL, IA 50327

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 658	Continued From page 25	F 658		

medications except one (1) before she realized that was not medication she had taken before. The resident requested a printed list of medications ordered. The assigned nurse had to leave the facility early so a different nurse took the keys to the medications cart. Nurse came in to room with the current medication list and went through medications with the resident. The resident showed the nurse the medications left in her medications cup and asked what it was. After medication review the nurse knew the medication had not been one currently ordered for her. The nurse went back to the medications cart and looked through the other resident's medications cards who had orders for the medications that had been in the resident's medication cup. One resident had been in the hospital for many days and would not have receive her medications at the facility during the day but her bubble pack had been punched through. The nurse went back to the resident's bubble pack to see if hers had been punched out and noticed the previous nurse who worked the cart had administered a different resident's medication.

According to an email 10/6/21 at 1:25 p.m., Staff I, Registered Nurse (RN) confirmed the resident received the following medications on 7/6/21 which had been prescribed for Resident #25:

a. Metoprolol 12.5 milligrams (mg's) - (high blood pressure)
b. Metformin 1000 mg - (diabetes mellitus (DM)
c. Venlafaxine 75 mg - (depression)
d. Bumex 2 mg - (fluid retention and high blood pressure)
e. Aspirin 81 mg -
f. Isosorbide 10 mg - (heart failure)

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 _____	C 10/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKRIDGE SPECIALTY CARE	5800 NE 12TH AVENUE PLEASANT HILL, IA 50327

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 658	Continued From page 26 g. Hydralazine 10 mg - (high blood pressure) h. Amiodarone 200 mg - (heart rhythm) During an interview 9/3/21 at 12:45 p.m., Staff I, Registered Nurse (RN) indicated the resident took the medications of Resident #25. The staff member confirmed the resident felt a little dizzy following the administration of the medications with no other adverse reactions. During an interview 10/6/21 at 1:33 p.m. the Resident confirmed there had been a mix up with her medications while she resided at the nursing facility but she had been unaware how many, if any, other resident's medications she took on 7/6/21. The resident confirmed she felt dizzy following the administration of medications per normal. 6. An observation of a medication pass 9/15/21 at 1:11 p.m. revealed Staff H, Registered Nurse (RN) as she attempted administration of a medication Requip 0.5 milligrams (mgs) one (1) three (3) times a day (TID) and Saline Nasal Spray 1 spray to each nostril four (4) times a day to Resident #7 who refused the medication. When asked why the refusal the resident stated because she received her morning doses at 11:10 a.m. Review of an Administration History Report form dated 9/15/21 at 2:41 p.m. indicated Resident #7 received her Requip and Saline Nasal Spray on 9/15/21 at 10:53 a.m. During an interview 9/23/21 at 10:59 a.m. a Pharmacist indicated with Requip if not evenly spaced the medication had not been therapeutic and his concern had been the gap between the	F 658		

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 _____	C 10/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKRIDGE SPECIALTY CARE	5800 NE 12TH AVENUE PLEASANT HILL, IA 50327

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 658	Continued From page 27	F 658		

PM dose the evening/night before and the AM dose. The Pharmacist stated from a therapeutic standpoint the windows at been nice but if the facility staff extended windows to make sure they covered their dosage the window made no sense.

7. An Administration History Report form dated 9/29/21 at 3:11 p.m. documented Resident #12 with the following orders and the actual times administered for medications schedule for the AM meds (7 a.m. - 9 a.m.)

a. Amiodarone HCL 200 mg tablet by mouth (po) two (2) times a day (BID) for her heart - administered at 10:10 a.m.
b. Anoro Ellipta Aerosol Powder Breath Activated 62.5-25 micrograms (MCG) per inhale 1 puff orally one time a day (QD) for acute and chronic respiratory failure with hypoxia - administered at 10:10 a.m.
c. APAP (Tylenol) 25 mg 2 tablets po every 4 hours for pain control. - administered at 3:05 a.m., 10:10 a.m. and 1:01 p.m.
d. Apixaban 5 mg tablet po BID for atrial fibrillation - administered at 10:10 a.m.
e. Furosemide 40 mg tablet po BID for heart failure - administered at 10:11 a.m.
f. Gabapentin 100 mg tablet po TID for shoulder pain - administered at 10:11 a.m.
g. Metoprolol tartrate 25 mg tablet po BID for heart - administered at 10:18 a.m.
h. Midodrine HCL 5 mg tablet 0.5 po TID for blood pressure - administered at 10:11 a.m.
i. Midodrine HCL 5 mg tablet po TID for blood pressure - administered at 10:11 a.m.
j. Myrbetiq extended release 24 hour 50 mg tablet po QD for overactive bladder - administered at 10:11 a.m.
k. Omeprazole capsule delayed release 20

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 _____	C 10/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKRIDGE SPECIALTY CARE	5800 NE 12TH AVENUE PLEASANT HILL, IA 50327

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 658	Continued From page 28 mg capsule po QD for GERD - administered at 10:11 a.m. l. Potassium Chloride ER tablet extended release 20 milliequivalents (MEQ) one tablet po QD for supplements - administered at 10:11 a.m. m. Synthroid 50 MCG tablet po QD for the thyroid - administered at 10:11 a.m. During an interview 9/3/21 at 12:07 p.m. the resident stated the facility staff administered her 8 a.m. pills until 10:30 a.m. 8. A MDS assessment form dated 9/21/21 documented Resident #14 had diagnosis that included DM, chronic obstructive pulmonary disease (COPD), cellulitis of the left lower limb, peripheral vascular disease and morbid obesity. The assessment documented the resident with a BIMS score of 13 (cognitively intact). During an interview and observation 9/1/21 at 10:05 a.m. the resident stated she thought on 8/31/21 the facility staff failed to have administered her evening pills until 11 p.m. and they were scheduled for 7 p.m. - 8 p.m. The resident indicated she went to the nurse's station to get her pills and one of the aides told her the nurse would get there when she gets there. An observation at the same time revealed a plastic medication cup full of the resident's morning medications positioned on her bedside stand. The resident stated nurses always left her medications for her to take because they knew she would take them. During an observation 9/1/21 at 10:35 a.m. the resident administered the medications in the plastic medication cup as stated above however, during the process 1 pill dropped on the dirty floor	F 658		

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 _____	C 10/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKRIDGE SPECIALTY CARE	5800 NE 12TH AVENUE PLEASANT HILL, IA 50327

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 658	Continued From page 29	F 658		

and the resident picked it up and proceeded to swallow the pill. Also noted a white pill positioned on the floor to the right of the resident along the baseboard. The pill had been later identified as a Tramadol 50 mg pill. According to a Physician Orders form the resident received an order for Tramadol 50 mg 2 pill po TID on 8/27/21.

9. During an interview 9/1/21 at 1:51 p.m., Staff M, CNA confirmed there had been times she observed resident's medications as set up and left unattended in individual resident rooms for self-administration.

During an interview 9/1/21 at 2:15 p.m., Staff O, CNA confirmed she observed resident's medications as set up and left unattended in individual resident rooms for self-administration.

During an interview 9/3/21 at 10:10 a.m., Staff P, CNA confirmed he occasionally observed medications left in resident's room unattended and for self-administration mainly from the 2 p.m. until 10 p.m. shift.

10. A Medications, Administration policy dated 1/2015 included the following documentation:

Purpose:

a. To assure that each resident received the proper medications at the correct time as ordered by their physician.

b. To have provided correct medications in the correct dose to the correct resident.

c. To have established a systematic approach of administration of medications to the residents.

Guidelines:

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 _____	C 10/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKRIDGE SPECIALTY CARE	5800 NE 12TH AVENUE PLEASANT HILL, IA 50327

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 658	Continued From page 30 a. Observation of the act of swallowing. b. Maintenance of a locked medication cart whenever not in direct sight during medication administration.	F 658		
F 677 SS=E	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, clinical record review, staff interview and resident interview, the facility failed to provide baths/showers for 4 of 4 sampled (Resident #3, #7, #14 and #18) for bathing services, failed to provide toilet assistance for 1 of 6 sampled (Resident #17) for toilet assistance, and failed to properly transfer 2 of 4 residents sampled (Resident #8 and #10) for transfers. The facility identified a census of 84 residents. Findings include: 1. A Minimum Data Set (MDS) assessment dated 2/26/21 documented Resident #3 had diagnoses of diabetes mellitus, non-alzheimer's dementia, muscle weakness and morbid obesity. Resident #3 had a Brief Interview for Mental Status (BIMS) score of "7", indicating severe cognitive impairments. Resident #3 required extensive assistance of two staff with transfers , non-ambulatory and dependent on one staff for showers. The Care Plan dated 1/28/21 directed staff to	F 677		

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 _____	C 10/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKRIDGE SPECIALTY CARE	5800 NE 12TH AVENUE PLEASANT HILL, IA 50327

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 677	Continued From page 31	F 677		

provide assistance with my activities of daily living, prefers showers, and one staff assistance with bathing.

The POC Response History form dated 8/19/21 to 8/31/21 failed to reflect Resident #3 received a bath.

2. A MDS assessment dated 8/4/21 documented Resident #7 had diagnoses of diabetes mellitus, anxiety, chronic obstructive pulmonary disease (COPD) and cerebellar ataxia. Resident #7 had a BIMS score of "12", indicating moderate cognitive impairments. Resident #7 required extensive assistance of one staff with bathing and extensive assistance of 2 staff with toilet use. Resident #7 had frequent bladder incontinence.

A Care Plan with a Focus initiated 2/7/14 revealed Resident #7 required staff assistance with all activities of daily living and directed staff to provide assistance of one staff with bathing.

During an interview 9/2/21 at 10:06 a.m. 10:35 a.m. and 10:35 a.m., Resident #7 confirmed she preferred to have used the toilet when she urinated and/or had a bowel movement but due to waiting for staff she had to use a bed pan. Resident #7 stated she had even called the nurse's station because she had to go to the bathroom. The phone rang and rang and no one answered.

A Bath Group form revealed Resident #7 had a bed bath scheduled on every Tuesday and Friday. The form revealed the following:

a. On 8/3/21, no bed bath.

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 _____	C 10/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKRIDGE SPECIALTY CARE	5800 NE 12TH AVENUE PLEASANT HILL, IA 50327

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 677	Continued From page 32 b. On 8/5/21, no bed bath. c. On 8/11/21, no bed bath. d. On 8/13/21, received a bed bath. e. On 8/16/21, received a bed bath. f. On 8/18/21, no bed bath. A POC Response History form documented the following: a. On 8/24/21, no bed bath. b. On 8/31/21, no bed bath. c. On 9/7/21, received a bed bath at 1:33 p.m. During an interview on 9/7/21 at 12:15 p.m., Resident #7 stated she had not received a bed bath on 9/3/21 and had not yet received one on this date and began to cry. 3. A MDS assessment dated 9/21/21 documented Resident #14 had diagnoses of diabetes, chronic obstructive pulmonary disease, cellulitis of the left lower limb, peripheral vascular disease and morbid obesity. Resident #14 had a BIMS score of "13", indicating intact cognition and required one staff assist for transfers. The Care Plan directed staff to provide assistance with activities of daily living and one staff assistance for bathing. A POC Response History form revealed Resident #14 had bath schedule on every Monday, Wednesday, and Friday morning. The form	F 677		

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 _____	C 10/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKRIDGE SPECIALTY CARE	5800 NE 12TH AVENUE PLEASANT HILL, IA 50327

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 677	Continued From page 33	F 677		

revealed the following:

a. On 8/24/21, no bath.

b. On 8/26/21, received bath.

c. On 8/27/21, no bath.

d. On 8/30/21, no bath.

e. On 9/1/21, no bath.

f. On 9/3/21, no bath.

g. On 9/6/21, no bath.

During an interview on 9/1/21 at 10:05 a.m., Resident #14 stated she went 2-3 weeks without a shower because the facility had been short staff and she really got upset with no showers.

During an interview on 10/1/21 at 10:40 a.m., Resident #14 confirmed she preferred to shower according to her scheduled days of every Monday, Wednesday, and Friday.

4. The MDS assessment dated 8/17/21 documented Resident #18 had a BIMS score of "13", indicating intact cognition. Resident #18 required extensive assistance of 1 staff with bathing.

The Care Plan revised on 9/30/20 revealed Resident #18 required staff assistance with activities of daily living, preferred showers, and one staff assistance with bathing.

A POC Response History form with a look back period of 14 days from 9/7/21 revealed Resident

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 _____	C 10/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKRIDGE SPECIALTY CARE	5800 NE 12TH AVENUE PLEASANT HILL, IA 50327

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 677	Continued From page 34 #18 had a bath scheduled every Tuesday and Friday. The form revealed the following: a. On 8/27/21, no bath. b. On 8/31/21, received a bath. c. On 9/3/21, no bath. d. On 9/7/21, received a bath. During an interview on 9/3/21 at 12:07 p.m., Resident #18 reported she preferred to bath 2 times a week. During an interview on 9/7/21 at 12:30 p.m., Resident #18 confirmed the facility staff failed to offer her a bath on 9/7/21. 5. During an interview on 8/31/21 at 3:20 p.m., Staff L (Certified Nurse Aide) confirmed staff unable to shower every resident according to the bathing schedules. During an interview 9/1/21 at 1:51 p.m., Staff M (Certified Nurse Aide) confirmed staff as unable to have showered each resident according to their individual schedules due to staff issues. During an interview 9/1/21 at 2:15 p.m., Staff O (Certified Nurse Aide) confirmed the staff were unable provide baths as scheduled. An email dated 10/6/21 at 3:05 p.m., the Administrator confirmed the facility staff followed the standard of care for 2 baths a week unless a resident requested and/or had been care planned for 1.	F 677		

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 _____	C 10/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKRIDGE SPECIALTY CARE	5800 NE 12TH AVENUE PLEASANT HILL, IA 50327

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 677	Continued From page 35	F 677		

6. The MDS assessment dated 9/13/21 documented Resident #17 had diagnoses of diabetes and morbid obesity. The assessment documented the resident had a BIMS score of "12", indicating intact cognition. Resident #17 required extensive assistance of 1 staff with toilet use and as frequently incontinent of urine.

A Care Plan with a Focus area initiated 6/4/18 and revised 6/22/18 documented the resident required staff assistance with ADL's.

During an observation and an interview 8/2/21 at 7:59 a.m. according to a Companion One box located at the nurse's station the residents call light had been on for 26:31 minutes. During an interview at 8:00 a.m., Resident #17 stated she had her call light on for almost 1/2 hour and required placement on a bed pan.

7. A MDS assessment form dated 4/16 documented Resident #8 had diagnosis that included multiple sclerosis, morbid obesity, muscle weakness, abnormal posture, arthritis and osteoporosis. The assessment documented the resident with a BIMS score of 12, required extensive assistance of 2 staff with transfers, non-ambulatory and with no falls.

A Care Plan with a Focus area initiated 8/4/15 and revised 7/1/16, documented the resident at risk for falls due to poor balance and her history of falls. The Care Plan directed the staff to provide assistance of 2 staff with an assistive device for all of my transfers.

An Incident Report form dated 5/20/21 at 11:00 p.m. documented the resident as lowered to the floor by a Certified Nurse Aide (CNA). As the

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 _____	C 10/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKRIDGE SPECIALTY CARE	5800 NE 12TH AVENUE PLEASANT HILL, IA 50327

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 677	Continued From page 36	F 677		

CNA transferred the resident by herself to a recliner via a lift device, the resident felt tired and started to go down so the CNA lowered her to the floor. The resident had been alert and oriented times (x) 3 and received passive range of motion to all extremities without and complaints of pain or injury noted.

During an interview on 8/27/21 at 1:00 p.m., the Resident confirmed she transferred with a lift device and there had been times staff used the assistive device and 1 staff assistance because there had not been enough staff scheduled for proper ADL assistance. The resident stated there had been no problem with falls since she slid down through the assistive lift device harness because the facility staff used the bigger harness which caused a fall with no injury. The resident indicated she felt safer with 2 staff assistance and a lift device for all transfers.

During an interview on 8/17/21 at 1:25 p.m., Staff N (Certified Nurse Aide) confirmed Staff Q (Certified Nurse Aide) self-transferred the Resident with a lift device and lowered the Resident to the floor with no injury.

During an interview on 8/17/21 at 1:34 p.m., Staff Q (Certified Nurse Aide) confirmed she self-transferred the Resident with the use of a lift device when she lowered the Resident to the floor with no injury.

7. The MDS assessment dated 7/16/21 documented Resident #10 had diagnoses of diabetes, arthritis, non-alzheimer's dementia, osteoarthritis and a history of falls. Resident #10 had a BIMS score of "6", indicating severe cognitive impairments and required extensive

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 _____	C 10/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKRIDGE SPECIALTY CARE	5800 NE 12TH AVENUE PLEASANT HILL, IA 50327

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 677	Continued From page 37 assistance of 2 staff with transfers. A Care Plan revised on 9/6/21 documented Resident #10 had a self care deficit and required assistance with activities of daily living and had impaired balance during transitions. The Care Plan directed staff to provide 2 staff assistance with an assistive devices with transfers. During an observation on 9/2/21 at 1:27 p.m. revealed a Certified Nurse Aide and Staff J (Certified Nurse Aide) connected an assistive device to Resident #10 and failed to attach the leg safety strap. 8. During an interview 8/31/21 at 3:06 p.m. Staff K (Certified Nurse Aide) indicated he believed the company policy with a transfer of a resident with an assistive device as 2 staff assistance. During an interview on 8/31/21 at 3:20 p.m., Staff L (Certified Nurse Aide) indicated it depended on the individual resident's Care Plan with guidance on how many staff required to transfer a resident with an assistive device but as a rule they used 2 staff with every machine. During an interview on 9/1/21 at 1:51 p.m., Staff M (Certified Nurse Aide) reported the facility required 2 staff for transfers requiring an assistive device transfers. During an interview on 9/3/21 at 10:10 a.m., Staff P (Certified Nurse Aide) confirmed residents required 2 staff assistance with all transfers that required assistive devices. The staff member offered their had been CNA's that had gotten into trouble when they independently transferred a resident who required an assistive device.	F 677		

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 _____	C 10/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKRIDGE SPECIALTY CARE	5800 NE 12TH AVENUE PLEASANT HILL, IA 50327

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, clinical record review, staff interviews, and facility policy review, the facility failed to provide and document adequate assessments of skin conditions and implement timely and consistent interventions (skin treatments) for 2 of 2 residents reviewed that experienced skin rashes and a laceration (Resident #1 & #3). The facility identified a census of 84 residents. Findings include: 1. A Minimum Data Set (MDS) assessment form dated 2/2/21 indicated Resident #1 had diagnosis the included diabetes mellitus, thyroid disorder, morbid obesity, moderate protein-calorie malnutrition, requires assistance with ADL's, muscle weakness, and acute kidney failure. The assessment indicated the resident scored 15 of 15 possible points on the Brief Interview for Mental Status (BIMS) test which meant the resident demonstrated intact cognitive abilities. The MDS documented the resident did not walk and required extensive assist of 2 staff with bed mobility and surface-to-surface transfers. The assessment also documented the resident had a	F 684		

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 _____	C 10/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKRIDGE SPECIALTY CARE	5800 NE 12TH AVENUE PLEASANT HILL, IA 50327

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 39 surgical wound and was not on a turning or repositioning program. An MDS assessment form dated 2/17/21 documented Resident #1 demonstrated modified independence with decision-making and experienced difficulty in new situations only. A Care Plan created on 1/26/21 documented the resident had a potential for skin integrity impairment related to impaired mobility, incontinence of bowel and bladder, presence of a Jackson Pratt (JP) drain for wounds, and a rash to bilateral upper and lower extremities initiated 2/5/21 and revised 2/26/21. The Care Plan directed staff to: a. Monitor, remind, and assist to turn and reposition frequently (initiated 1/26/21 and revised 2/26/21) b. Monitor for and document locations, size, and treatment of the skin injury; report abnormalities, failure to heal, signs and symptoms of infection, maceration, etc. to the physician (initiated 2/5/21 and revised 2/26/21) The TAR form dated 2/1/21 - 2/28/21 directed staff to cleanse the resident's right, lower with wound cleanser, followed by an application of TAO (triple antibiotic ointment) and cover with gauze daily on day shift for wound care initiated on 2/6/21 at 6 a.m. and discontinued on 2/26/21 at 10:44 a.m. Review of this form revealed staff failed to provide the resident's treatment on 2/7 and 2/12 - 2/14. During an interview 9/9/21 at 3:41 p.m. the resident confirmed the staff failed to provide the treatments to her rashes in accordance with	F 684		

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 _____	C 10/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKRIDGE SPECIALTY CARE	5800 NE 12TH AVENUE PLEASANT HILL, IA 50327

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 40 physician's orders, which was why they increased in size. A Wound Treatment Plan form dated 2/3/21 documented the resident had the following skin issues: a. Right leg - Etiology: dermatitis that measured 1.3 centimeters (cm's) x (by) 1.0 cm x 0.1 cm deep, new tissue with 100% scab; unable to assess wound bed, exudate and odor = none, periwound = dry and scaly and mechanically debrided during the assessment. b. Right lower abdomen - Etiology: unknown (dermatitis versus yeast) that measured 0.9 cm x 1.3 cm x 0.1 cm; wound status: new; tissue = 100% biofilm; unable to assess the wound bed; exudate = moderate amount of thin, serous drainage, no odor, periwound dry and intact. Wound mechanically debrided during assessment. Record review revealed no further assessments of the above documented areas and identified the resident discharged from the facility on 2/24/21. 2. An MDS assessment form dated 2/26/21 documented Resident #3 had diagnosis that included diabetes mellitus (DM), non-Alzheimer's dementia, muscle weakness and morbid obesity. The assessment documented the resident with a Brief Interview for Mental Status (BIMS) score of 7 out of 15 (severe cognitive impairment), with fluctuating inattention and disorganized thinking, required extensive assistance of two (2) staff with bed mobility and transfers and as non-ambulatory. The assessment documented	F 684		

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 _____	C 10/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKRIDGE SPECIALTY CARE	5800 NE 12TH AVENUE PLEASANT HILL, IA 50327

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 41	F 684		

the resident had no open areas and not on a turning/repositioning program.

A Care Plan documented the resident experienced decreased mobility and incontinence (initiated and revised 1/28/20) and required staff assistance with activities of daily living (initiated and revised 1/28/20). The Care Plan directed staff to assist with repositioning to avoid skin friction/shearing and provide daily observation of skin with routine cares (initiated 1/28/20). The Care Plan also included the resident required a full skin evaluation weekly with bath/shower (initiated and revised 1/28/20).

A Progress Notes entry dated 6/1/21 at 3:02 p.m. documented a laceration to the resident's right lateral calf that measured 2.9 cm x 1.7 cm x 0.0 cm, with a scabbed wound bed and no exudates noted.

A Progress Notes entry dated 8/12/21 at 3:49 p.m. revealed a laceration to the resident's right lateral calf that measured 1.5 cm x 2.4 cm x 0.0 cm with no further assessment documented.

A Skin & Wound Evaluation form dated 8/25/21 at 11:18 a.m. documented the laceration to the resident's right lateral calf as resolved. The exact date the facility acquired laceration occurred had been documented as 5/18/21.

During an interview on the morning of 9/1/21, the Director of Nursing (DON) verified facility staff failed assess the resident's skin issues prior to her (the DON's) arrival four (4) weeks ago.

A Change of Condition/Hot Chart Protocol facility policy dated 1/2015 documented its purpose: to

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 _____	C 10/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKRIDGE SPECIALTY CARE	5800 NE 12TH AVENUE PLEASANT HILL, IA 50327

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 42 provide care to residents through nursing assessments, interventions, and appropriate follow up.	F 684		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, clinical record review, staff interviews, and facility policy review, the facility failed to provide adequate assessments and interventions for 2 of 4 residents reviewed that experienced significant changes in condition (Resident #1 & #3). The facility identified a census of 84 residents. Findings include: 1. An MDS assessment form dated 2/2/21 indicated Resident #1 had diagnosis the included diabetes mellitus, thyroid disorder, morbid obesity, moderate protein-calorie malnutrition, requires assistance with ADL's, muscle weakness, and acute kidney failure. The	F 686		

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 _____	C 10/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKRIDGE SPECIALTY CARE	5800 NE 12TH AVENUE PLEASANT HILL, IA 50327

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 43	F 686		

assessment indicated the resident scored 15 of 15 possible points on the Brief Interview for Mental Status (BIMS) test which meant the resident demonstrated intact cognitive abilities. The MDS documented the resident did not walk and required extensive assist of 2 staff with bed mobility and surface-to-surface transfers. The assessment also documented the resident as at risk for pressure sores, but with no pressure sores and not on a turning or repositioning program.

An MDS assessment form dated 2/17/21 documented Resident #1 demonstrated modified independence with decision-making and experienced difficulty in new situations only. The MDS assessment documented the resident had three (3) Stage III pressure ulcers (full thickness tissue loss; subcutaneous fat may be visible but bone, tendon or muscle not exposed; slough may be present but does not obscure the depth of the tissue loss and may include undermining and tunneling.)

A Care Plan created on 1/26/21 documented the resident with a pressure related to injury to her skin and also included a potential for skin integrity impairment related to impaired mobility, incontinence of bowel and bladder and presence of a Jackson Pratt (JP) drain for wounds initiated 2/5/21 and revised 2/26/21. The Care Plan directed staff to:

a. Monitor, remind, and assist to turn and reposition frequently (initiated 1/26/21 and revised 2/26/21)
b. Follow facility protocols for treatment of injury (initiated 2/5/21 and revised 2/26/21)
c. Monitor for and document locations, size, and

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 _____	C 10/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKRIDGE SPECIALTY CARE	5800 NE 12TH AVENUE PLEASANT HILL, IA 50327

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 44	F 686		

treatment of the skin injury; report abnormalities, failure to heal, signs and symptoms of infection, maceration, etc. to the physician (initiated 2/5/21 and revised 2/26/21)

A Treatment Administration Record (TAR) form dated 2/1/21 - 2/28/21 directed staff to apply a Triad Hydrophilic Wound Dress Paste (wound dressings) to the right and left buttocks and the coccyx topically every shift for wound care initiated 2/5/21 at 10 p.m. and discontinued (dc' d) 2/26/21 at 10:44 a.m.

Review of the above TAR dated 2/1/21 - 2/28/21 revealed facility staff failed to provide the resident's treatment on:

a. Day shift on 2/7, 2/8, and 2/12 - 2/14/21
b. Evening shift on 2/6, /2/8, and 2/15/21
c. Night shift 2/8, 2/15, and 2/17 - 2/19/21

During an interview 9/9/21 at 3:41 p.m. the resident confirmed the pressure ulcers first presented themselves in the hospital, however they were "little." She added when she arrived at the facilty, the ulcers increased in size and staff failed to provide the treatments to the pressure ulcers and her rashes in accordance with physician's orders, which was why they increased in size.

A Wound Treatment Plan form dated 2/3/21 documented the resident had the following skin issues:

a. Right buttock - Etiology: Stage III pressure area that measured 2.0 x 2.6 cm x 0.1 cm; wound status: new, tissue = 50% biofilm and 50% epithelial; unable to assess wound bed; exudate

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 _____	C 10/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKRIDGE SPECIALTY CARE	5800 NE 12TH AVENUE PLEASANT HILL, IA 50327

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 45 = moderate amount of thick serous drainage, no odor, periwound intact and moist. Wound mechanically debrided during the assessment. b. Left buttock - Etiology had been a stage III pressure area that measured 5.5 cm x 3.2 cm x 0.1 cm, wound status had been new, tissue = 90% biofilm and 10% epithelial, unable to have assessed the wound bed, exudate = moderate amount thin serous drainage, no odor, periwound intact and moist. Wound mechanically debrided during the assessment. c. Coccyx = Etiology Stage III pressure area that measured 3.0 cm x 2.0 cm x 0.1 cm, wound status: new, tissue = 100% slough, unable to assess the wound bed, exudate = moderate amount thin, sanguineous drainage, no odor, periwound intact and moist. Wound mechanically debrided during the assessment. Record review revealed no further assessments of the above documented areas and identified the resident discharged from the facility on 2/24/21. 2. A Minimum Data Set (MDS) assessment dated 2/26/21 documented Resident #3 had diagnosis that included diabetes mellitus (DM), non-Alzheimer's dementia, muscle weakness and morbid obesity. The assessment documented the resident with a Brief Interview for Mental Status (BIMS) score of 7 out of 15 (severe cognitive impairment), with fluctuating inattention and disorganized thinking, required extensive assistance of two (2) staff with bed mobility and transfers and as non-ambulatory. The assessment documented the resident as at risk for pressure ulcers but with no open areas and	F 686		

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 _____	C 10/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKRIDGE SPECIALTY CARE	5800 NE 12TH AVENUE PLEASANT HILL, IA 50327

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 46 not on a turning/repositioning program.	F 686		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation and facility policy review, the facility failed to provide adequate nursing supervision by maintaining an environment free of hazards in an attempt to prevent injury for 3 residents (Residents #7, #8, and #10). The facility also failed to maintain a a locked medication cart whenever not in direct sight during medication administration. The facility identified a census of 84 residents. Findings include: 1. An MDS assessment form dated 4/16/21 documented Resident #8 had diagnoses that included multiple sclerosis, morbid obesity, muscle weakness, abnormal posture, arthritis, and osteoporosis. The assessment documented the resident had a BIMS score of 12 (moderately impaired cognitive abilities), required extensive assist of 2 staff for transfers, did not walk, and had experienced no falls. A Care Plan initiated 8/4/15 and revised 7/1/16	F 689		

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 _____	C 10/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKRIDGE SPECIALTY CARE	5800 NE 12TH AVENUE PLEASANT HILL, IA 50327

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 47	F 689		

documented the resident as at risk for falls due to poor balance and a history of falls. The Care Plan directed staff to provide assist of 2 and an assistive device for all surface-to-surface transfers (initiated 2/16/18 and revised 11/24/20).

An Incident Report form dated 5/20/21 at 11 p.m. documented as the CNA transferred the resident by herself to a recliner using a lift device, the resident felt tired and started to go down, so the CNA lowered her to the floor. The form showed the resident as alert and oriented to person, place, and time and received passive range of motion to all extremities without complaints of pain or injury noted.

During an interview 8/27/21 at 1 p.m., the resident verified staff transferred her a lift device and there had been times staff used device alone because there had not been enough staff scheduled to use 2 staff for transfer assistance. The resident stated there had been no problem with falls since staff used the bigger lift harness and she slid through it. She said although she had no injuries from the fall, she felt safer with assist of 2 staff and a lift device for all transfers.

During an interview 8/17/21 at 1:25 p.m., Staff N, CNA confirmed Staff Q, CNA used the lift to transfer Resident #8 by herself and had to lower the resident to the floor with no injury.

During an interview 8/17/21 at 1:34 p.m., Staff Q, CNA confirmed she used the lift to transfer Resident #8 by herself and had to lower the resident to the floor with no injury.

2. A MDS assessment form dated 7/16/21 documented Resident #10 had diagnosis that

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 _____	C 10/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKRIDGE SPECIALTY CARE	5800 NE 12TH AVENUE PLEASANT HILL, IA 50327

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 48 included DM, arthritis, non-Alzheimer's dementia, osteoarthritis and a history of falls. The assessment documented the resident with a BIMS score of 6 (severe cognitive impairment) and required extensive assist of 2 staff for surface-to-surface transfers. A Care Plan initiated 7/30/21 and revised 9/6/21 documented the resident showed an ADL self-care deficit as evidenced by impaired balance during transitions and requires assist with ADL's. The Care Plan directed staff to provide assist of 2 staff and interventions included provide assist of 2 staff with an assistive device with transfers (initiated 7/30/21 and revised 9/6/21). A observation 9/2/21 at 1:27 p.m. revealed an unknown CNA and Staff J, CNA as they connected an assistive device to the resident for a safe transfer and failed to attach the leg strap for safety. During an interview 8/31/21 at 3:06 p.m. Staff K, Certified Nursing Assistant (CNA) indicated he believed company policy required 2 staff to transfer of a resident with an assistive device. as 2 staff assistance. During an interview 8/31/21 at 3:20 p.m. Staff L, CNA indicated it depended on the individual resident's Care Plan to direct the number of staff required to transfer a resident with an assistive device, but as a rule they used 2 staff with every machine. During an interview 9/1/21 at 1:51 p.m., Staff M, CNA said the facility required 2 staff to help with assistive device transfers.	F 689		

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 _____	C 10/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKRIDGE SPECIALTY CARE	5800 NE 12TH AVENUE PLEASANT HILL, IA 50327

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 49 During an interview 9/3/21 at 10:10 a.m., Staff P, CNA confirmed resident required 2 staff to assist with all transfers that required assistive devices. The staff member added there had been CNA's that had gotten into trouble when they independently transferred a resident that required an assistive device for transfers. An observation 9/1/21 at 9:20 a.m. revealed an unlocked and unattended medication cart which contained various resident medications, eye drops, inhalers and etc positioned up against a wall a the nurse's station without staff present. An observation 9/7/21 at 3:15 p.m. revealed an unlocked and unattended medication cart which contained various resident medications, eye drops, inhaliers, etc. positioned in the hallway along the wall to the left of room 200 without Staff E, certified medication aide (CMA) present and in the area. Staff F, Certified Medication Aide exited room 202 and when the medication cart had been identified as unlocked she said "oops, sorry." An observation 9/15/21 at 4:20 p.m. revealed an unlocked, unattended treatment cart positioned along the wall to the right of room 205. The treatment cart contained several different creams and ointments as well as treatment supplies. Staff G, Licensed Practical Nurse (LPN) exited room 205 and said she was sorry when showed the unlocked treatment cart. An observation 9/2/21 at 9:55 a.m. in Resident #7's room revealed a portable cylinder oxygen tank not contained or stabilized to prevent it from falling.	F 689		

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 _____	C 10/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKRIDGE SPECIALTY CARE	5800 NE 12TH AVENUE PLEASANT HILL, IA 50327

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 50 A Medications, Administration policy dated 1/2015 directed staff to maintain a locked medication cart whenever not in direct sight during medication administration.	F 689		
F 725 SS=E	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on record review, observation, resident	F 725		

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 _____	C 10/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKRIDGE SPECIALTY CARE	5800 NE 12TH AVENUE PLEASANT HILL, IA 50327

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 725	Continued From page 51	F 725		

and staff interview, the facility failed to ensure call lights and were answered in a timely manner (no longer than 15 minutes) to meet residents' needs for 6 of 6 residents reviewed. (Residents #1, #4, #7, #12, #17 and #18) and failed to properly transfer 2 residents that required assist of two (2) staff with a lift device (Residents #8 and #10). The facility reported a census of 84 residents.

Findings include:

1. An observation 9/1/21 at 9:46 a.m. revealed the call light for room 309 on for 44:32 minutes at the call light monitoring box positioned at the nurse's station.

2. An observation 9/2/21 at 7:59 a.m. revealed the call light for Resident #17 on for 26:31 minutes at the call light monitoring box positioned at the nurse's station.

During an interview 9/2/21 at 8 a.m., the resident confirmed her call light was on for almost 1/2 hour and she needed staff to assist her on to the bedpan.

During an interview 9/2/21 at 10:35 a.m. the resident stated her call light had been on but staff failed to answer, so she called the nurse's station because she had to go to the bathroom and no one answered the telephone.

3. An observation 9/21/21 at 9:45 a.m. revealed the call light on for Resident #12 on for 31:28 minutes as various staff members walked the residents' hallways, but did not answer the call lights.

4. During an interview 9/9/21 at 3:41 p.m.

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 _____	C 10/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKRIDGE SPECIALTY CARE	5800 NE 12TH AVENUE PLEASANT HILL, IA 50327

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 725	Continued From page 52	F 725		

Resident #1 confirmed her call light was frequently on for more than 15 minutes, however she could not specify the actual amount of time due to no clock in her room. She offered that she had to wait so long more and more often and had became incontinent one of the times. She added she was normally continent of urine and this caused her to to feel like a little kid and not very good.

5. During an interview 9/23/21 at 10:44 a.m., Resident #4 indicated his colostomy leaked so he activated his call light. He timed the staff response with his wall clock and noted it took up to 1 ½ hours for staff to answer, which caused him humiliation.

6. An MDS assessment form dated 8/4/21 documented Resident #7 with diagnoses that included diabetes mellitus, anxiety, chronic obstructive pulmonary disease (COPD), and cerebellar ataxia. The assessment documented the resident with a BIMS score of 12 (moderately impaired cognitive abilities) and required extensive assistance of 2 staff for toilet use. The MDS also documented the resident experienced frequently urine incontinence and was always continent of bowel.

A Care Plan initiated 2/7/14 documented the resident required staff assistance with all activities of daily living (ADL's) and directed staff to provide assist of 1 for toilet use.

During an interview 9/2/21 at 10:06 a.m. Resident #7 confirmed she preferred to use the toilet to urinate and defecate, but due to lack of staff she had to utilize the bed pan.

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 _____	C 10/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKRIDGE SPECIALTY CARE	5800 NE 12TH AVENUE PLEASANT HILL, IA 50327

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 725	Continued From page 53	F 725		

During an interview 9/2/21 at 10:35 a.m. Resident #7 confirmed she timed staff call light response (up to 2 hours) using the wall clock. She said the wait made her mad because she had to go to the bathroom really bad and could not hold her urine for that length of time. The resident verified staff had failed to bathe her every Tuesday and Friday as scheduled and added there had been times she had not received a bath/shower for 4 weeks.

7. During an observation/interview 9/3/21 at 12:04 p.m. Resident #18 sat on the toilet in her room and stated she had been waiting for over 20 minutes for someone to answer her call light and assist her to wipe herself. Observation of the call light monitor at the nurse's station at 11:58 a.m. revealed the resident's call light was on for 30:42 minutes.

8. Review of the facility's call light log (printed) revealed the following calls lights on as documented:

a. 8/27/21 - Room 204 B at 8:41 p.m. - 54 minutes

b. 8/27 - 216 A at 9:15 a.m. - 34 minutes
8/28 at 7:29 a.m. - 3 hours and 14 minutes
8/28 at 8:07 a.m. - 1 hour and 10 minutes
8/29 at 1:02 p.m. - 36 minutes
9/2 at 7:59 a.m. - 28 minutes
9/3 at 8:56 a.m. - 1 hour and 32 minutes

c. 8/27- 312 B at 8:49 a.m. - 30 minutes
8/27 at 9:35 a.m. - 33 minutes
8/27 at 10:19 a.m. - 4 hours and 33 minutes
8/27 at 4:50 p.m. - 1 hour and 41 minutes
8/27 at 7:40 p.m. - 41 minutes

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 _____	C 10/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKRIDGE SPECIALTY CARE	5800 NE 12TH AVENUE PLEASANT HILL, IA 50327

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 725	Continued From page 54 8/28 at 1:39 p.. - 17 minutes 8/29 at 8:24 pm.. - 3 hours and 5 minute 8/31 at 12:16 p.m. - 31 minutes 8/31 at 4:50 p.m. - 21 minutes 9/1 at 7:59 a.m. - 3 hours and 31 minutes 9/1 at 2:35 p.m. - 28 minutes 9/1 at 8:05 p.m. - 25 minutes 9/1 at 8:57 p.m. - 58 minutes 9/2 at 8:42 a.m. - 48 minutes 9/2 at 1:40 p.m. - 42 minutes 9/2 at 2:31 p.m. - 24 minutes 9/3 at 9:35 a.m. - 23 minutes d. 8/27 - 315 A at 8:23 a.m. - 40 minute. 8/27 at 1:30 p.m. - 4 hours and 35 minutes 8/28 at 10 a.m. - 24 minutes 8/29 at 12:32 a.m. - 21 minutes 8/30 at 8:21 a.m. - 1 hour and 38 minutes 8/31 at 1:52 p.m. - 45 minutes 8/31 at 3:31 pm. - 35 minutes 9/1 at 4:10 p.m. - 44 minutes e. 8/27 - 304 A - 1:30 p.m. - 4 hours and 32 minutes 8/27 at 7:15 p.m. - 3 hours and 13 minutes 8/28 at 2:01 p.m. - 32 minutes 8/28 at 7:21 p.m. - 34 minutes 8/31 at 9:50 a.m. - 31 minutes 8/31 at 12:59 p.m. - 2 hours and 34 minutes 9/2 at 1:11 p.m. - 24 minutes f. 8/27 - 208 B at 8:20 a.m. - 1 hour and 27 minutes 8/27 at 11:16 a.m. - 45 minutes 8/27 at 1:46 p.m. - 28 minutes 8/27 at 5:41 p.m. - 30 minutes 8/27 at 7:34 p.m. - 48 minutes. 8/28 at 4:31 p.m. - 20 minutes	F 725		

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 _____	C 10/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKRIDGE SPECIALTY CARE	5800 NE 12TH AVENUE PLEASANT HILL, IA 50327

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 725	Continued From page 55 8/28 at 7:42 p.m. - 1 hour and 21 minutes 8/28 at 9:42 p.m. - 44 minutes 8/29 at 12:17 p.m. - 29 minutes 8/29 at 1:07 p.m. - 1 hour and 9 minutes 8/29 at 3:37 p.m. - 45 minutes 8/30 at 7:39 a.m. - 25 minutes 8/30 at 8:28 a.m. - 1 hour and 1 minute 8/30 at 10:05 a.m. - 47 minutes 8/30 at 11:38 a.m. - 2 hours and 15 minutes 8/30 at 9:19 p.m. - 36 minutes 8/31 at 8:36 a.m. - 5 hours and 34 minutes 9/1 at 9:18 a.m. - 28 minutes 9/1 at 1:50 p.m. - 25 minutes 9/2 at 9:02 a.m. - 32 minutes 9/2 at 8:46 a.m. - 24 minutes 8. During an interview 8/31/21 at 3:20 p.m., Staff L, Certified Nursing Assistant (CNA) confirmed staff are unable to answer resident call lights within 15 minutes. During an interview 9/1/21 at 1:51 p.m., Staff M, CNA confirmed staff could not answer resident call lights within 15 minutes. During an interview 9/1/21 at 2:15 p.m., Staff O, CNA confirmed staff as unable to answer resident call lights within 15 minutes. 9. Review of an undated facility form revealed 26 of 84 residents required assist of 2 staff and a lift device for surface-to-surface transfers. Review of an undated facility form revealed 3 of 84 residents required assist of 2 staff without the use of a transfer device. 10. An MDS assessment form dated 4/16	F 725		

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 _____	C 10/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKRIDGE SPECIALTY CARE	5800 NE 12TH AVENUE PLEASANT HILL, IA 50327

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 725	Continued From page 56	F 725		

documented Resident #8 had diagnoses that included multiple sclerosis, morbid obesity, muscle weakness, abnormal posture, arthritis, and osteoporosis. The assessment documented the resident had a BIMS score of 12, required extensive assist of 2 staff for transfers, did not walk and had experienced no falls.

A Care Plan initiated 8/4/15 and revised 7/1/16 documented the resident as at risk for falls due to poor balance and a history of falls. The Care Plan directed staff to provide assist of 2 and an assistive device for all surface-to-surface transfers (initiated 2/16/18 and revised 11/24/20).

An Incident Report form dated 5/20/21 at 11 p.m. documented as the CNA transferred the resident by herself to a recliner using a lift device, the resident felt tired and started to go down, so the CNA lowered her to the floor. The form showed the resident as alert and oriented to person, place, and time and received passive range of motion to all extremities without complaints of pain or injury noted.

During an interview 8/27/21 at 1 p.m., the resident verified staff transferred her a lift device and there had been times staff used device alone because there had not been enough staff scheduled to use 2 staff for transfer assistance. The resident stated there had been no problem with falls since staff used the bigger lift harness and she slid through it. She said although she had no injuries from the fall, she felt safer with assist of 2 staff and a lift device for all transfers.

During an interview 8/17/21 at 1:25 p.m., Staff N, CNA confirmed Staff Q, CNA used the lift to transfer Resident #8 by herself and had to lower

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 _____	C 10/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKRIDGE SPECIALTY CARE	5800 NE 12TH AVENUE PLEASANT HILL, IA 50327

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 725	Continued From page 57	F 725		

the resident to the floor with no injury.

During an interview 8/17/21 at 1:34 p.m., Staff Q, CNA confirmed she used the lift to transfer Resident #8 by herself and had to lower the resident to the floor with no injury.

11. A MDS assessment form dated 7/16/21 documented Resident #10 had diagnosis that included DM, arthritis, non-Alzheimer's dementia, osteoarthritis and a history of falls. The assessment documented the resident with a BIMS score of 6 (severe cognitive impairment) and required extensive assist of 2 staff for surface-to-surface transfers.

A Care Plan initiated 7/30/21 and revised 9/6/21 documented the resident showed an ADL self-care deficit as evidenced by impaired balance during transitions and requires assist with ADL's. The Care Plan directed staff to provide assist of 2 staff and interventions included the following as dated:

a. 2 person assistance with an assistive devices with transfers. (initiated 7/30/21 and revised 9/6/21).

A observation 9/2/21 at 1:27 p.m. revealed an unknown CNA and Staff J, CNA as they connected an assistive device to the resident for a safe transfer and failed to attach the leg strap for safety.

12. During an interview 8/31/21 at 3:06 p.m. Staff K, Certified Nursing Assistant (CNA) indicated he believed company policy required 2 staff to transfer of a resident with an assistive device. as 2 staff assistance.

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 _____	C 10/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKRIDGE SPECIALTY CARE	5800 NE 12TH AVENUE PLEASANT HILL, IA 50327

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 725	Continued From page 58 During an interview 8/31/21 at 3:20 p.m. Staff L, CNA indicated it depended on the individual resident's Care Plan to direct the number of staff required to transfer a resident with an assistive device, but as a rule they used 2 staff with every machine. During an interview 9/1/21 at 1:51 p.m., Staff M, CNA said the facility required 2 staff to help with assistive device transfers. During an interview 9/3/21 at 10:10 a.m., Staff P, CNA confirmed resident required 2 staff to assist with all transfers that required assistive devices. The staff member added there had been CNA's that had gotten into trouble when they independently transferred a resident that required an assistive device for transfers.	F 725		
F 802 SS=F	Sufficient Dietary Support Personnel CFR(s): 483.60(a)(3)(b) §483.60(a) Staffing The facility must employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, taking into consideration resident assessments, individual plans of care and the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.60(a)(3) Support staff. The facility must provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. §483.60(b) A member of the Food and Nutrition	F 802		

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 _____	C 10/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKRIDGE SPECIALTY CARE	5800 NE 12TH AVENUE PLEASANT HILL, IA 50327

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 802	Continued From page 59 Services staff must participate on the interdisciplinary team as required in § 483.21(b)(2)(ii). This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. The facility identified a census of 84 residents. Findings include: 1. An observation 9/1/21 at 12:15 p.m. revealed a certified nursing assistant (CNA) as she served meal trays and drinks on the 300 hallway with all items uncovered. 2. An observation 9/2/21 at 8:10 a.m. revealed facility staff as they served residents in the main dining room with Styrofoam plates and bowls and plastic silverware and glasses. 3. An observation 9/2/21 at 12 p.m. revealed the facility staff as they served the residents' juices and milk in plastic glasses. 4. During an interview Staff B, CNA confirmed the facility staff served the breakfast meal on Styrofoam and plastic due to not enough dietary staff. The staff member stated dietary served meals a lot lately on Styrofoam and plastic due to lack of dietary staff. 5. During an interview Staff C, dietary stated she had been the only staff member who worked/cooked in the kitchen on 9/2/21 since 6 a.m. The staff member stated the maintenance man had assisted to serve the residents their	F 802		

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 _____	C 10/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKRIDGE SPECIALTY CARE	5800 NE 12TH AVENUE PLEASANT HILL, IA 50327

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 802	Continued From page 60 breakfast in the small dining room, activity room, and all of 300-400 hallway residents.	F 802		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, staff and resident interview and facility policy review, the facility failed to properly distribute and serve food in accordance with professional standards for meal service. The facility identified a census of 84 residents. Findings include: 1. An observation 9/1/21 at 12:15 p.m. revealed a certified nursing assistant (CNA) serving meal trays and drinks on the 300 hallway with all items	F 812		

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 _____	C 10/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKRIDGE SPECIALTY CARE	5800 NE 12TH AVENUE PLEASANT HILL, IA 50327

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 812	Continued From page 61 uncovered. 2. An observation 9/2/21 at 8:10 a.m. revealed facility staff as they served residents in the main dining room using styrofoam plates and bowls and plastic silverware and glasses. 3. An observation 9/2/21 at 12 p.m. revealed the facility staff as they served juices and milk in plastic glasses. 4. During an interview Staff B, CNA confirmed the facility staff served the resident's breakfast meal on styrofoam and plastic due to not enough dietary staff. The staff member stated dietary served meals a lot lately on styrofoam and plastic due to lack of dietary staff. 5. During an interview Staff C, dietary stated she had been the only staff member who worked/cooked in the kitchen on 9/2/21 since 6 a.m. The staff member stated the maintenance man had assisted to serve the residents their breakfast in the small dining room, activity room and all of 300-400 hallway residents. 6. Review of a Dining Room Service policy dated 2/2016 directed staff to maintain a comfortable and attractive atmosphere in the dining room area(s) and serve residents' meals in a courteous and dignified manner. 7. Review of a Room Tray Dining policy dated 2/2016 directed staff to serve foods at proper temperatures using insulated plate covers, coffee pots or mugs and bowl and cover all food and deliver food promptly after plating.	F 812		

The facility denies that the alleged facts as set forth constitute a deficiency under interpretations of Federal and/pr State law. Preparation and/or execution of this plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in this statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provision of federal and/or state law.

Credible allegation of compliance date: Monday, November 1st, 2021

F 558

Residents #4, #7,#14,#20,#21,#26 as well as all residents at Parkridge Specialty Care will have their dietary needs met appropriately prior to and at the conclusion of meals.

Director of Nursing conducted education to nursing department on the timeliness of room tray removal.

Random audits will be conducted by management to ensure timeliness of room tray removal.

Dietary Service Manager conducted education to dietary employees on ensuring the use of proper utensils, plates, and cups for reasonable accommodation of resident needs and preferences.

F 580

Resident #3, as well as all residents of Parkridge Specialty Care, will have their family or responsible party notified of any significant condition changes.

Director of Nursing conducted education to nursing on proper notification of changes to residents.

Director of Nursing and/or Nurse Management to audit daily (Monday-Friday) during AM clinical standup meeting.

F 584

Residents #1, #7, #9, #11, #14, as well as all residents of Parkridge Specialty Care, will have a clean, sanitary, and homelike environment.

Administrator hired a new Maintenance Director to ensure residents have a safe, clean, comfortable, and homelike environment.

Administrator created and hired a new position of Housekeeping and Laundry supervisor to ensure residents have a safe, clean, comfortable, and homelike environment.

Housekeeping and Laundry Supervisor will conduct random cleaning audits.

Housekeeping and Laundry Supervisor enforced new cleaning expectations to the environmental department.

Director of Nursing and Nurse Management will conduct random audits to ensure overnight employees are cleaning wheelchairs.

F 609

Resident #13, as well as all the residents of Parkridge Specialty Care, will have all alleged violations of abuse, neglect, exploitation or mistreatment reported timely to appropriate government agencies.

Administrator and management of each department educated employees on different types of abuse.

Administrator and management of each department educated employees on reporting abuse to the Abuse Coordinator.

Abuse Coordinator name and contact information posted for employees viewing.

F 610

Resident #13, as well as all residents at Parkridge Specialty Care, will have alleged instances of abuse reported to the Administrator and then in turn, reported to the appropriate government agency, according to the guidelines of reporting.

Administrator and management of each department educated employees on different types of abuse.

Administrator and management of each department educated employees on reporting abuse to the Abuse Coordinator.

Abuse Coordinator name and contact information posted for employees viewing.

F 657

Residents #2, #7, and #8, as well as all residents at Parkridge Specialty Care, will have accurate and updated plans of care.

Random kardex and care plan audits to be conducted by Director of Nursing and Nurse Management.

Concerns to be brought to AM standup meeting and addressed for accurate care planning.

Education to nursing department on the location and use of Kardex.

Administrator and management of each department to conduct daily rounds.

F 658

Residents #1, #2, #14, #24, #7, #12, #18, as well as all residents at Parkridge Specialty Care, will receive medication administration services that meets professional standards.

Director of Nursing educated nursing department on proper medication pass times.

Director of Nursing educated nursing department on following treatment administration records.

Director of Nursing and Nurse Management to conduct random treatments audits. Concerns to be brought to AM clinical standup meeting.

Director of Nursing and Nurse Management to conduct daily monitoring of any gaps in the MAR/TAR.

Director of Nursing and Nurse Management to conduct random medication audits. Concerns to be brought to AM clinical standup meeting.

Random audits to be conducted to ensure medication carts of locked.

Administrator and management of each department to conduct daily rounds to ensure medication carts are locked and medications are not left in the room unattended by nurse.

Privacy screens ordered and placed on nurse computers.

F 677

Residents #3, #7, #14, #18, #17, #8, #10, as well as all the residents at Parkridge Specialty Care, will have adequate ADL services to maintain good nutrition, grooming, and personal and oral hygiene.

Director of Nursing and Nurse Management to conduct daily monitoring of bathing and discuss in AM clinical standup meeting.

Random makeup bathing audits to be conducted by Director of Nursing and Nurse Management.

Director of Nursing conducted education for nursing department on bathing regulations.

Director of Nursing and Nurse Management to conduct random transfer audits.

Administrator and management of each department to conduct random call light audits.

F 684

Residents #1, #3, as well as all residents at Parkridge Specialty Care, will provide and document adequate assessments of skin conditions and implement timely and consistent interventions.

Director of Nursing and Informatics team conducted education for nursing department on the use of the skin module in PCC.

Administrator created position and hired full-time Wound Nurse.

Wound Nurse enrolled in Vohr Wound Training course.

Director of Nursing and Nurse Management conducted education to nursing department for weekly skin assessments.

Director of Nursing and Nurse Management to discuss skin and wounds daily in AM clinical standup meeting.

F 686

Residents #1, #3, as well as all residents at Parkridge Specialty Care, will receive adequate skin assessments and interventions.

Director of Nursing and Wound Nurse to conduct weekly reviews of skin pressure areas. Results to be brought and discussed in daily AM clinical standup meeting.

Administrator created position and hired full-time Wound Nurse.

Wound Nurse enrolled in Vohr Wound Training course.

Director of Nursing and Informatics team conducted education for nursing department on the use of the skin module in PCC.

Director of Nursing to complete Telligen training on pressure ulcer care and prevention.

Weekly weight and wound meetings conducted.

Director of Nursing and Nurse Management to discuss skin and wounds daily in AM clinical standup meeting.

Director of Nurse and Nurse Management to reviews Bradens as needed.

F 689

Residents #7, #8, #10, as well as all residents at Parkridge Specialty Care, will be in an environment that is as free of accidents and hazards as is possible.

Director of Nursing and Nurse Management to conduct random transfer audits.

Administrator and management of each department to conduct daily rounds.

Maintenance Director to conduct random equipment checks.

Random audits to be conducted to ensure medication carts of locked.

Administrator and management of each department to conduct random call light audits.

Director of Nursing and Nurse Management conducted education on oxygen tank safety/stabilization for safety.

Random transfer audits to be conducted by Director of Nursing and Nurse Management.

F 725

Residents #1, #4, #7, #12, #17, #18, as well as all the residents at Parkridge Specialty Care, will have sufficient numbers of staff to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychological well-being of each resident.

Administrator and management of each department to conduct random call light audits.

Director of Nursing and Nurse Management conducted education on timeliness of call light response time.

Social Services department to conduct random call light response time conversations with residents.

Walkie talkies ordered to increase communication and assist in timely call light response time.

Maintenance Director to conduct random call light maintenance checks.

F 802

Residents at Parkridge Specialty Care will have sufficient dietary staff to provide support personnel to safety and effectively carry out the functions of the food and nutrition service.

Administrator created position and hired full-time Dietary Service Manager Assistant.

Education conducted on covering room trays.

Education conducted on Styrofoam and plastic to not be utilized unless resident is on isolation.

Revision of meal service to increase efficiency of meal service.

Dietary Service Manager sent to sister facility for increased training on meal service.

F 812

The residents of Parkridge Specialty Care will have their food procured, stored, and distributed in accordance with the professional standards for meal service.

Administrator created position and hired full-time Dietary Service Manager Assistant.

Education conducted on covering room trays.

Education conducted on Styrofoam and plastic to not be utilized unless resident is on isolation.

Revision of meal service to increase efficiency of meal service.

Dietary Service Manager sent to sister facility for increased training on meal service.

Dietician to conduct random audits on proper passing of room trays.

Thank you,

Kelsey Anderson

Kelsey Anderson, Administrator