STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165147	A. Building B. Wing	12/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Park Place	401 South Van Buren Mount Pleasant, IA 52641

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Plan the resident's discharge to meet the resident's goals and needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22506 Based on clinical record review, receiving facility staff interview, and discharging staff interviews the facility failed to provide an accurate representation of a resident's behaviors and to ensure discharge needs are identified within the discharge planning process for one of one residents (Resident #1) reviewed. The facility reported census was 36. Findings include: The Minimum Data Set (MDS) dated [DATE], included an incomplete Brief Interview for Mental Status (BIMS). The BIMS is used to determine cognitive status. Section C, for Cognitive Patterns indicated Resident #1 had short term and long term memory problems, and moderate impaired cognitive skills for daily decision making. Section E, for Behavior indicated Resident #1 wandered daily; and wandering significantly intruded on the privacy or activities of others. Section E indicated Resident #1 did not display hallucinations or delusions. The MDS documented Resident #1 independent with transfers and ambulation. The MDS list of diagnoses included: non-Alzheimer's disease, anxiety disorder, and depression. The Care Plan, dated 9/11/24 included a plan to address LTC (long term care) Elopement Risk. Interventions included, in part; Code Alert Bracelet on My Wrist or Ankle, Staff Will Keep Areas Safe for Me When I Am Wandering. The Care Plan also included a plan to address LTC Behavioral Symptoms, and a plan to address LTC Delirium. During an interview on 12/23/24 at 12:50 p.m., Staff A, Certified Nurse Aide (CNA), stated Resident #1 was confused and would wander into other resident rooms and may get in their bed or use their bathroom. Resident #1 was easily redirected, but the behavior was almost constant while awake. During an interview on 12/23/24 at 1:25 p.m. Staff B, CNA stated resident Resident #1 would often wander into other resident's rooms and beds and was difficult to get out. Resident #1 would exit seek and wore a wander guard. (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165147	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/24/2024
NAME OF PROVIDER OR SUPPLIER Park Place		STREET ADDRESS, CITY, STATE, ZIP CODE 401 South Van Buren Mount Pleasant, IA 52641	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/23/24 at 4:05 p.m. Staff D, Social Worker, stated they had accepted some residents from a closing facility on an emergency basis with no intention of keeping them permanently. Staff D stated she put out faxed referrals to facilities and called some. One local facility voiced an interest. Staff D was queried whether family was involved in the decision to transfer and she stated she was uncertain. Staff D was then queried what information was shared with the facility, specifically to Resident #1's behaviors. Staff D stated she knew Resident #1 wandered, but was unaware of him going into other resident rooms. During an interview on 12/23/24 at 4:50 p.m. the Director of Nursing (DON) stated their organization took 14-16 residents when another facility closed unexpectedly. Two of those residents, including Resident #1, ended up at their facility. Both residents had been on a memory care unit and were not suitable for their environment, so they quickly started looking for placement. The DON recalled another facility showing interest and remembered briefly meeting with their Director of Nursing. The DON stated Resident #1 was hard of hearing and wandered, but was easily redirected. The DON was not aware of Resident #1 frequently entering other resident rooms. The DON stated she had visited with the family and discussed finding Resident #1 a suitable living place. The DON stated she thought the layout of the other facility, which did not have a memory care unit, would be more suitable for Resident #1. During an interview on 12/23/24 at 3:00 p.m. the Director of Nursing at the receiving facility stated she made an on-site visit to see Resident #1 prior to accepting him to their facility. The receiving facility Director of Nursing stated Resident #1 was presented as a resident from another facility that had closed and who had no significant behaviors. The day of the visit, Resident #1 was laying in his bed watching TV. The Social Worker, Staff D stated this is all he does. Staff D stated he wanders some and has a wander guard, but does not exit seek. Staff D never disclosed Resident #1's behavior of going into other resident rooms. Upon arrival at their facility on 9/25/24, Resident #1 immediately started following female residents into their rooms and required frequent redirection to the point of 1:1 supervision within the first 24 hours of admission. They were able to get family to come in and help and within two days found a more suitable placement to address Resident #1's supervision needs.