STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165234	A. Building B. Wing	10/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Parkview Manor	516 Thirteenth Street Wellman, IA 52356

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, policy review, provider and staff interviews, the facility failed to develop interventions to meet the resident's discharge goals and needs to ensure a smooth and safe transition from the facility to a post-discharge setting. (Resident #3) The facility reported census was 47. Findings include: The Minimum Data Set (MDS), dated [DATE], listed diagnoses for Resident #3 included: diabetes mellitus, and neurogenic bladder. The Brief Interview for Mental Status (BIMS) score of 15 out of 15 indicated intact cognition. The MDS assessed Resident #3 required moderate assistance with transfers, mobility, dressing, toilet use and personal hygiene needs and was occasionally incontinent of bladder. The MDS documented Resident #3 had taken a hypoglycemic (medication used to lower blood sugar, includes insulin). A review of the clinical record revealed a Nurses Note, dated 8/30/24 at 9:55 a.m., documenting Resident #3 given discharge information. Reviewed signs and symptoms of high and low blood sugar and to check blood sugar and to continue to check blood sugars before meals and that should track for new physician and take to first appointment, Reviewed infections signs and symptoms and to notified doctor if experiencing any S& (sign and symptoms) for further instruction regarding care. Shower bench going with resident and all belongings have been packed and put on transport van. Medication scripts being faxed to [pharmacy name redacted] in [name of town redacted]. (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

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F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/9/24 at 9:40 a.m. Staff I, Social Worker, stated she met with representatives with Resident #3's Managed Care Organization discuss the discharge plans. Staff I was unable to provide the date and time of this meeting, and used email exchanges for reference. Staff I described Resident #3's discharge placement as a host home with two adult foster parents. Staff I stated Resident #3 was in need of a shower chair, home health services and medication administration assistance. Following the meeting, Staff I stated she was able to obtain the shower chair, but home health services could not be provided until Resident #3 was seen by a physician, not affiliated with the facility. Staff I seemed to believe she would not be the one to set up this appointment and was unaware who may of made the referral and when the appointment was, leaving home health services for Resident #3 uncertain. Staff I stated the Director of Nursing (DON) was working on the medications which included the need for insulin and supplies. Staff I stated the pharmacy they use was unable to provide insulin supplies so they had to change pharmacies last minute. Staff I was unaware of any issues related to the pharmacy change and was uncertain who would be administering the insulin and whether they were trained. Resident #3 was discharged on [DATE] without having home health services arranged or of a clear understanding how the medications would be given. During an interview on 10/9/24 at 10:47 a.m. Staff J, Registered Nurse, stated she attended a care conference in which Resident #3's discharge plans were discussed. Staff J recalls the Nurse Practitioner (NP) sending scripts to their pharmacy and there being an issue with the insulin and insurance. The NP then sent scripts to another pharmacy and there was an issue in the way the insulin was ordered and the NP had to re-order the insulin. Staff J stated she didn't know anything more about the discharge. During an interview on 10/14/24 at 12:56 p.m. Staff CM, Case Manager, stated they had found placement for Resident #3 in a host home through a community provider. The home had a married couple who would provide supervision and support 24/7. Staff CM stated they had met with the facility and began planning the discharge, but prior to the discharge, Resident #3 was hospitalized and diagnosed with diabetes mellitus requiring the use of insulin. Staff CM stated she suggested moving the discharge back, but the facility wanted to move forward. The discharge was scheduled on a Friday (8/30/24), which can be problematic if there are any issues. The plan was to have a 30 day supply of medications sent home with Resident #3. Apparently there was an issue and they had to switch pharmacies as well as discovering the insulin dosage and type of administration type was wrong. Staff CM stated the facility never contacted her about any issues and by Sunday or Monday she reached out and found out about the problems. Staff CM stated she found out about the incorrect insulin dosage and how they sent out insulin bottles instead of a quick pen. Staff CM stated she spent several hours trying to get the right scripts sent to the pharmacy. Staff CM stated she also questioned whether Resident #3 was properly trained on insulin administration as he kept bending needles. Staff CM stated they were able to get an appointment scheduled with a physician and home health services started in the home. Staff CM stated there was a lack of communication and proper planning by the facility to insure a smooth transition. A review of the clinical record revealed a lack of documentation regarding discharge planning for Resident #3 prior to the discharge on 8/30/24 at 9:55 a.m. During an interview on 10/14/24 at 1:34 p.m. Staff HH, Host Home, stated there was a lot of miscommunication surrounding the discharge of Resident #3. Staff HH stated as a result Resident #3 went without his medications, including his insulin for over a week. Staff HH stated Resident #3 is doing fine now. (continued on next page)

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F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A facility policy, dated April 2017, titled Discharge Planning Process review revealed A Policy Interpretation and Implementation section directing the Interdisciplinary Team, which includes the resident and/or representative: 1. Evaluate the resident ' s discharge potential and needs; 2. Develop a discharge plan as part of the comprehensive care plan which includes: a. The resident ' s goals of care and treatment preferences; b. The resident ' s interest in being discharged or transferred; c. Needs of the resident upon discharge; d. Capacity of the resident and care givers to meet the needs of the resident upon discharge/transfer; e. Is the discharge/transfer feasible - who made this decision and why; f. Names of the Interdisciplinary Team involved in developing the discharge plan; g. Documented and dated resident ' s involvement and h. Date when the discharge plan was reviewed and updated 3. Share the discharge plan with the resident and/or representative 4. Update the discharge plan as needed 5. Prepare the resident and/or representative for discharge 6. Document reason for discharge or transfer 7. Provide required information 8. Complete a discharge summary