STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165472	A. Building B. Wing	04/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Scenic Manor	1409 Fremont Street Iowa Falls, IA 50126

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 0661 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure necessary information is communicated to the resident, and receiving health care provider at the time of a planned discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42441 Based on clinical record review, family, and staff interview, the facility failed to ensure a resident had prescription medication readily available following discharge for 1 of 3 residents reviewed (Resident #3). The facility reported a census of 61 residents. Findings include: The Minimum Data Set (MDS) dated [DATE] revealed Resident #3 had an admitted [DATE] and a planned discharge date of [DATE]. The Care Plan initiated 1/8/24 revealed Resident #3 planned to return to the community with a goal to successfully return to the community after meeting all goals at the facility and a safe return to the community. Review of undated facility form titled, Discharge Summary/Post Discharge Plan Of Care, reflected the facility arranged pharmacy services for Resident #3 at a pharmacy in [NAME]. Review of an electronic mail (email) correspondence dated 2/5/24 at 8:37 AM to Staff A, Admission Coordinator, revealed a family member of Resident #3 inquired about the resident's prescription medication as the discharge papers indicated they would be at the pharmacy, but the pharmacy didn't have anything there. Review of email correspondence dated 2/5/24 at 8:40 AM to Staff A revealed a family member requested Staff A to fax the discontinued orders to the pharmacy as Resident #3 didn't have her medication yesterday. The family member further revealed she was concerned about the resident not having her medication for 2 days. During an interview 4/29/24 at 3:00 PM the Administrator revealed they did not have a policy in place regarding a discharge protocol other than for Care Planning. During an interview 4/30/24 at 10:31 AM, the Director of Nursing (DON) revealed she faxed Resident #3's physician's office the day before (4/29/24) to see if the physician had a note about the pharmacy reaching out to the clinic regarding her discharge medications. The clinic provided documentation revealing the pharmacy had reached out to their clinic on 2/5/24. (continued on next page)

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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0661 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of faxed documentation from Resident #3's primary provider revealed on 2/5/24 at 5:31 PM the provider listed the medications sent to the pharmacy. The provider further documented the pharmacy never received the fax from the nursing home that the nursing home said they sent regarding the medications. During an interview 4/30/24 at 10:31 AM, the DON stated it had never happened before where a resident didn't receive their medication right after discharging. The DON further revealed they don't usually use the pharmacy that Resident #3 used except this one time and stated moving forward they will contact that pharmacy to ensure they have received the order for discharge medications. The DON added they expected residents to have their medication lined up and available when discharging so that they don't miss a dose.