

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165578	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/16/2024
NAME OF PROVIDER OR SUPPLIER Premier Estates of Muscatine		STREET ADDRESS, CITY, STATE, ZIP CODE 3440 Mulberry Avenue Muscatine, IA 52761	

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)
<p>F 0660</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Plan the resident's discharge to meet the resident's goals and needs.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26529</p> <p>Based on record review, and staff and resident responsible party interviews, the facility failed to ensure the discharge needs of each resident were met when they transferred a resident to the wrong facility, a facility that had no knowledge of the resident, had not agreed to accept the resident's transfer, and did not have authorization to admit the resident because they were not a Veteran Administration (VA) contracted service provider, for 1 of 3 resident's reviewed for discharge coordination (Resident #1). The facility reported a census of 56 residents</p> <p>Findings include:</p> <p>The Minimum Data Set (MDS) Assessment tool dated 8/28/24 revealed Resident #1 admitted to the facility on [DATE], with diagnoses that included malignant neoplasm of the rectum, depression, hypertension (high blood pressure), and a surgical wound present, scored 15 out of 15 points possible on the Brief Interview for Mental Status (BIMS) cognitive assessment, that indicated no cognitive deficits, and without symptoms of delirium. The assessment revealed the resident received analgesics on a scheduled and as-needed basis in the 5 days that preceded the assessment for frequent pain that impacted the resident's sleep and day to day function, rated at an 8 at the worst level with a 0 to 10 pain scale used, 10 was assigned to the worst pain possible, and required substantial staff assistance to reposition in bed, transfer to and from bed and chair, dressing, toileting, and bathing, and unable to stand or ambulate. The assessment revealed the resident received Physical and Occupational Therapy services (Skilled Therapy) with a goal of discharge to the community, estimated at 3 or more months away.</p> <p>A Notice of Medicare Non-Coverage (NOMNC) form dated 9/6/24 revealed 9/9/24 was the resident's last day of covered Skilled Therapy services. The resident was a Veteran, with long term care (LTC) benefits available through the Veteran's Administration (VA), continued LTC after 9/9/24 required authorization and approval by the VA, at a facility under VA contract, and the facility did not have a VA contract.</p> <p>Nursing Progress Note entries transcribed by Staff A, the facility's Social Service Designee (SSD) revealed:</p> <p>8/28/2024 at 4:04 p.m. Care conference today with resident and family, plan is to discharge to home. If he should need more time, we will seek VA Nursing home.</p> <p>(continued on next page)</p>

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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<p>F 0660</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>9/9/24 at 12:19 p.m. Facility A (a LTC facility located 29 miles east of the facility) has accepted resident, They will call back and let SSD know transport time.</p> <p>9/9/24 at 1:10 p.m. Non-Emergent Transport (NET) to transport resident. Pick up time is 2:30 p.m.</p> <p>9/10/24 at 11:42 a.m. Discharge is set for 9/10/24 at 2:30 p.m. to Facility A. NET to transport. Pick up time is 2:30 p.m.</p> <p>9/10/24 at 4:00 p.m. Facility B.</p> <p>(Facility B was a sister facility of Facility A, located 109 miles south west of the facility. Facility B had a VA contract, Facility A did not).</p> <p>A Nursing Progress Note transcribed 9/10/24 at 4:38 p.m. by Staff B, Registered Nurse (RN), stated: Resident left facility at 1:45 p.m. for transport to Facility A. Family not present. Resident left with discharge paperwork, including medication list and Medication Administration Record (MAR). Later when I called Facility A to ask if they needed information, the call was transferred to a nurses station, received a recording to leave a message and left message with my contact information if they had any questions.</p> <p>Additional Nursing Progress Notes transcribed by Staff A revealed:</p> <p>9/11/24 at 8:25 a.m. SSD called resident's Power of Attorney (POA) to check on resident. He was admitted to Facility A for the night and transportation will be arranged to transfer to Facility B on 9/11/24.</p> <p>9/11/24 at 8:27 a.m. SSD placed a call to Staff C, Regional Clinical Admission Specialist for the corporation that owns Facility A and Facility B). Left message waiting for callback.</p> <p>9/11/24 at 1:56 p.m. Ambulance service to transport the resident from Facility A today. Ambulance service to callback and give estimated time of arrival.</p> <p>The facility's Transfer/Discharge - Outside the Facility policy dated 2/2015 directed:</p> <ol style="list-style-type: none"> 1. The Director of Social Services or designee assists with the process of resident and family/responsible party notification and processing of transfers outside of the facility. 2. Transfers or discharges initiated by the facility and not by the resident/or the resident's physician or family/responsible party may require the completion of state specific process and documentation. 3. Review facility process for managing transfers out of the facility, as needed, with the resident and family/responsible party upon admission. 4. Verify physician order for transfer/discharge is obtained. 5. Assist nursing staff with notification of the resident and family/responsible party of the following: <p>(continued on next page)</p>		

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<p>F 0660</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>a. Reason for and effective date of transfer.</p> <p>b. Location of transfer.</p> <p>c. Name, address, and telephone number of the Ombudsman and other parties/agencies required by the state, as indicated.</p> <p>6. Coordinate with the interdisciplinary team to provide information and education to prepare a resident to be discharged , as indicated.</p> <p>7. Assist staff with coordination and communication with resident and family/responsible party.</p> <p>Staff interviews revealed:</p> <p>9/12/24 at 1:56 p.m., Staff A, Social Service Designee (SSD) stated she had contacted the VA about the resident's continued care requirement, and spoke to Staff C, (Regional Clinical Admission Specialist) for Facility A's company. Staff C said she told me that Facility B had the VA contract, Facility A did not have a VA contract, but Staff A did not recall that, and believed the resident was supposed to transfer to Facility A, located 40 minutes away and accessible to the resident's family. She became aware the resident was transferred to the wrong facility late in the afternoon on 9/10/24 when she spoke to Staff C about it. Staff C told her they were going to get transportation for the resident to transfer to Facility B. She called her facility Administrator right away, who directed her to arrange transportation and bring the resident back to their facility. She spoke to Staff C again after that, who told Staff A that they were working on it.</p> <p>9/12/24 at 2:17 p.m., Staff C, RN, Regional Clinical Admission Specialists stated she spoke with Staff A on 8/29/24, told her Facility A did not have a VA contract, but Facility B did, there was a bed available, and they would start the process for approval through the VA. She had more communication with Staff A over the phone about the approval for Facility B and the planned discharge/transfer date. On 9/10/24 she received a phone call at 4:45 p.m. from Staff D, RN, Director of Nursing (DON) at Facility A, who told Staff C that the resident was at their facility. Staff C called Staff A right after that, Staff A said she had made a mistake, she had been talking to too many different facilities. Staff C stated the initial plan was to transport the resident back to the facility then, but she was unable to reach anyone at the facility by phone. Staff D and the Administrator at Facility A had to make arrangements for the resident to stay there until the following day when other arrangements could be made. The resident was transferred to Facility B on 9/11/24.</p> <p>(continued on next page)</p>		

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<p>F 0660</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>9/12/24 at 9:50 a.m., Staff D, RN, DON at Facility A, stated the resident was dropped off at their facility around 4 p.m. on 9/10/24. Their facility had no knowledge of the resident's admission or information about the resident. Fortunately the resident's family was with the resident, and she was able to reach Staff C, who told her the resident was supposed to go to Facility B. Staff D was unable to reach anyone at the resident's facility by phone, contacted the VA and had to get Facility A's Administrator and Medical Director involved to get orders for his care at their facility overnight until transportation arrangements could be made the following day. Their facility did not have a VA contract, the resident's care would not have been covered by the VA and this situation was challenging and complicated by their inability to contact anyone at the facility' on 9/10/24. Due to the resident's rectal area wound and pain, he would not have been able to tolerate transport to Facility B in a wheelchair van and needed to transport by ambulance as Facility B was a 2 and a half hour drive. After several phone calls on 9/11/24, the resident did transfer to Facility B by ambulance, late in the afternoon.</p> <p>9/12/24 at 10:31 a.m., Staff E, Care Coordinator at the VA, stated she spoke with the Administrator at Facility A, and Staff A on 9/11/24, and directed Staff A to make transportation arrangements by ambulance, to transport the resident from Facility A to Facility B, and the arrangements had to be made for that day. She received a phone message from Staff A at 2:10 p.m. on 9/11/24 that stated the resident would be transported by ambulance at 2:45 p.m. She then contacted Facility A at 3:30 p.m. to ensure the resident was transported, found out the resident was still there, and learned in later communication the resident did not leave Facility A until approximately 4:30 p.m. on 9/11/24.</p> <p>During an interview on 9/16/24 at 12:42 p.m., the resident's POA stated all the communication they had with Staff A about the resident's transfer was that he would go to Facility A, and that was acceptable. Staff A never discussed Facility B, and they would not have agreed for the resident to be placed that far away, that was a hardship to drive that far and they would have requested another facility closer to their location. They were at Facility A when the resident arrived there on 9/10/24, nobody at that facility knew anything about him, but they went above and beyond to try to do the right thing and make sure he was taken care of. The resident didn't arrive at Facility B until 7:00 p.m. on 9/11/24, it was a long day with a lot of phone calls going back and forth and waiting on information until they found out when the ambulance arrangements were finally made that afternoon.</p>		