

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265463	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/30/2024
NAME OF PROVIDER OR SUPPLIER Parkview Healthcare		STREET ADDRESS, CITY, STATE, ZIP CODE 128 North Hardesty Kansas City, MO 64123	

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 0623</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights.</p> <p>Based on interview and record review, the facility failed to provide a written discharge notice to one sampled resident (Resident #2) and/or his/her guardian upon emergency discharge from the facility out of five sampled residents. The facility census was 101 residents.</p> <p>Review of the facility's policy titled Transfer or Discharge Notice dated March 2021 showed residents and/or representatives were notified in writing, and in a language and format they understood, at least 30 days prior to a transfer or discharge.</p> <p>1. Review of Resident #2's discharge Minimum Data Set (MDS- a federally mandated assessment instrument completed by facility staff for care planning) dated 10/9/24 showed the resident was discharged on 10/9/24 and the resident's discharge was unplanned.</p> <p>Review of a nurse's note dated 10/9/24 at 3:14 P.M. showed the resident had called Emergency Medical Services (EMS) on himself/herself and was transported to a local hospital.</p> <p>Review of a nurse's note dated 10/9/24 at 6:30 P.M. showed:</p> <ul style="list-style-type: none"> -The Director of Nursing (DON) had given verbal emergency discharge notice to Guardian A. -Guardian A was to be provided the written discharge notice by fax during business hours the following day. <p>Review of the resident's care plan dated 10/14/24 showed no care plan related to any discharge planning.</p> <p>Review of the resident's Electronic Medical Record (EMR) on 12/30/24 showed no written discharge notice is the resident's chart.</p> <p>During an interview on 12/30/24 at 10:09 A.M. the DON said he/she had spoken at length with Guardian A related to the resident's discharge.</p> <p>During an interview on 12/30/24 at 11:15 P.M. the DON said the previous Administrator had told him/her that he/she had faxed a copy of the resident's written discharge notice to Guardian A.</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 0623</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 12/30/24 at 11:26 A.M. Guardian A said he/she was unsure if he/she had received a written discharge notice from the facility. He/she had no record of a written copy of the discharge notice.</p> <p>During an interview on 12/30/24 at 11:45 A.M. the DON said:</p> <ul style="list-style-type: none"> -He/She could not find a copy of the resident's written discharge notice. -He/She could only verify that a verbal notice had been provided. <p>During an interview on 12/30/24 at 1:59 P.M. Hospital Social Worker A said he/she was unable to find a written discharge notice in the resident's hospital records.</p> <p>During an interview on 12/30/24 at 2:29 P.M. Licensed Practical Nurse (LPN) A said:</p> <ul style="list-style-type: none"> -He/She was responsible for notifying a resident's Durable Power of Attorney (DPOA) if indicated when a resident discharges to a hospital. -The verbal notification would be in a nurse/progress note. -He/She was unsure who completed the written notification of discharge to residents. -He/She thought that the DON would be responsible for ensuring completion of all parts of the discharge notification process. <p>During an interview on 12/30/24 at 3:30 P.M. Social Services Designee (SSD) A said:</p> <ul style="list-style-type: none"> -He/She had not worked at the facility when the resident discharged from the facility. -The Administrator would be responsible to completing the written discharge notices and giving them to the residents and/or resident representative. -Written discharge notices needed to be given at least 30 days prior to the discharge from the facility. <p>During an interview on 12/30/24 at 4:03 P.M. the DON said:</p> <ul style="list-style-type: none"> -A written discharge notification should have been provided to the resident and/or Guardian A. -The previous Administrator had taken full responsibility for completing and giving all written discharge notices. -He/She should have followed up with the previous Administrator to ensure that the written notification had been faxed to Guardian A. <p>During an interview on 1/6/25 at 11:15 A.M. the acting Administrator said:</p> <ul style="list-style-type: none"> -He/She had thought that a discharge notice had been sent to Guardian A. <p>(continued on next page)</p>		

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<p>F 0626</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Permit a resident to return to the nursing home after hospitalization or therapeutic leave that exceeds bed-hold policy.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to permit one sampled resident (Resident #2) for re-admission to the facility out of five sampled residents. The facility census was 101 residents.</p> <p>Review of the facility's policy titled Bed-Hold and Returns dated March 2022 showed:</p> <p>-A resident would be permitted to return to an available bed in the location of the facility that he or she previously resided in.</p> <p>-If there was not an available bed in that part, the resident would be given the option to take the available bed in another distinct part of the facility and return to the previous distinct part when a bed were to become available.</p> <p>1. Review of Resident #2's discharge Minimum Data Set (MDS- a federally mandated assessment instrument completed by facility staff for care planning) dated 10/9/24 showed the resident was discharged on 10/9/24 and his/her return was not anticipated.</p> <p>Review of a nurse's note dated 10/9/24 at 3:14 P.M. showed the resident had called Emergency Medical Services (EMS) on himself/herself and was transported to a local hospital.</p> <p>During an interview on 12/6/24 at 11:05 A.M. Guardian A said:</p> <p>-The resident had been given an immediate discharge notice.</p> <p>-The resident was ready for discharge at that time from the hospital.</p> <p>-No other facilities had accepted him/her and the resident should be allowed back to the facility.</p> <p>-He/she had spoken with a previous Administrator who informed him/her that the facility would not be taking the resident back.</p> <p>During an interview on 12/20/24 at 10:09 A.M. the Director of Nursing (DON) said that the facility could no longer meet the needs of the resident and that was why he/she could not be re-admitted to the facility.</p> <p>During an interview on 12/30/24 at 11:26 A.M. Guardian A said:</p> <p>-The resident was still at the same local hospital the resident discharged to from the facility on 10/9/24.</p> <p>-The hospital had sent mass referrals to other facilities in the State, but all facilities had denied placement.</p> <p>During an interview on 12/30/24 at 1:52 P.M. Guardian A said:</p> <p>(continued on next page)</p>		

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<p>F 0626</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-He/She had been told by a previous Administrator that the facility could no longer meet the needs of the resident and that was why the facility denied re-admission to the facility.</p> <p>-During that conversation with the previous Administrator, the Administrator told him/her that the facility was willing to risk getting a citation and had been adamant about not letting the resident back into the facility.</p> <p>During an interview on 12/30/24 at 1:59 P.M. Hospital Social Worker A said:</p> <p>-The DON had told the Emergency Department (ED) social worker that the facility would not be accepting the resident back on 10/9/24.</p> <p>-The facility also declined the referral back to the facility on [DATE], 11/13/24, and 12/5/24.</p> <p>During an interview on 12/30/24 at 2:29 P.M. Licensed Practical Nurse (LPN) A said he/she was unaware that the resident had not been allowed back into the facility.</p> <p>During an interview on 12/30/24 at 2:55 P.M. the Director of Admissions said:</p> <p>-He/She had not worked at the facility prior to the resident's discharge and initial referrals to the facility.</p> <p>-He/She was aware that the facility was not allowing the resident to be re-admitted to the facility.</p> <p>-He/She had been told by the Administrator and DON that the resident was not allowed back to the facility.</p> <p>-The Clinical Team and the Business Office Manager (BOM) were responsible for reviewing referrals for admission to the facility.</p> <p>During an interview on 12/30/24 at 3:30 P.M. the Social Services Designee (SSD) said:</p> <p>-The facility would be responsible for ensuring the resident was allowed to re-admit to the facility.</p> <p>-The facility was going against the regulation.</p> <p>-He/She had not worked at the facility prior to the resident's discharge and was unaware of the situation.</p> <p>During an interview on 13/20/24 at 4:03 P.M. the DON said:</p> <p>-Per regulation, he/she understood that the resident was to be re-admitted to the facility.</p> <p>-He/She, the Administrator and the clinical team were responsible for denying the resident to be re-admitted to the facility.</p> <p>(continued on next page)</p>		

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