

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  165241	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  08/01/2024
NAME OF PROVIDER OR SUPPLIER  Grundy Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  102 East J Avenue Grundy Center, IA 50638	
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 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 35438</p> <p>Based on observation, document review and staff interview, the facility failed to ensure licensed nurse coverage 24 hours a day. On 6/15/24 the night nurse clocked out at 6:45 AM and the day nurse clocked in at 8:41 AM The facility did not have a licensed nurse on duty, in house during that time frame. The facility staff contacted the Director of Nursing (DON) and the Administrator who failed to act to immediately to provide licensed coverage. The facility identified 15 diabetic residents, 8 of whom are insulin dependent with one resident (Resident #7) who had a blood glucose reading of 65, during the time the facility didn't have no licensed nurse coverage. In addition, the facility had one resident (Resident #2) had a tracheostomy that required suctioning three times a day (TID) and as needed. The facility identified a census of 28 residents.</p> <p>Findings include:</p> <p>1. Resident #2's Minimum Data Set (MDS) assessment dated [DATE] reflected they sometimes could make themselves understood and sometimes understood others. The MDS identified Resident #2 had severely impaired cognitive skills for decision making. Resident #2 required total assistance with rolling side to side and transfers. The MDS included diagnoses of stroke, aphasia (inability to speak), and a tracheostomy.</p> <p>Resident #2's June 2024 Treatment Administration Record (TAR) included the following orders:</p> <p>a. Suction free of mucus and crusting at least 3 times a day with application of sterile saline suctioning as needed.</p> <p>b. Use humidified air to the tracheostomy as much as possible.</p> <p>c. Keep the area around the stoma area free of crusting and debris with gentle cleansing with half strength hydrogen peroxide solution every hour as needed.</p> <p>d. Provide trach cares, including removing and cleaning of the inner cannula.</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 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>On 7/31/24 at 12:15 PM Staff B, Registered Nurse (RN), demonstrated the emergency tracheostomy supplies and suction equipment located in Resident #2's bedside stand. Resident #2 required total assistance of 2 staff for repositioning and couldn't respond to verbal instructions. Staff B reported only a licensed nurse could provide suctioning and care of the tracheostomy and if the tracheostomy became dislodged or pulled out, the resident would need immediate intervention and transfer to the hospital.</p> <p>2. Resident #7's MDS assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) score of 4, indicating severely impaired cognitive skills for decision making. The MDS listed Resident #7 as independent with sit to stand and chair to bed transfer. The MDS included diagnoses of stroke, intellectual disability, and diabetes mellitus.</p> <p>The Care Plan Focus revised 2/20/24 indicated Resident #7 had diabetes mellitus type 2. The Interventions directed staff the following:</p> <ul style="list-style-type: none"> <li>a. Provide diabetic medication as ordered.</li> <li>b. Monitor and document for side effects and effectiveness.</li> <li>c. Monitor, document, report to provider signs and symptoms of hypoglycemia (low blood sugar less than 80) and hyperglycemia (elevated blood sugar greater than 150).</li> </ul> <p>Resident #7's June 2024 TAR included an order for Fiasp FlexTouch 100 unit/ml (insulin) pen injector, inject as per sliding scale three times a day dated as ordered 3/6/24. The TAR included the following blood sugar readings in the AM (morning) and insulin units injected: 6/14/24 Blood sugar 533 required 15 units of insulin, 6/15/24 65 required no insulin.</p> <p>During an interview on 7/30/24 at 2:28 PM, Staff C, Licensed Practical Nurse (LPN), stated on 6/15/24 she called and reported to the DON she would be late. Staff C responded when she arrived at the facility the other nurse had already left. The facility didn't have a nurse at the facility during that time. She reported being very surprised that the nurse left, leaving the facility without a licensed nurse. She expected the facility have a licensed nurse on duty at all times.</p> <p>In an interview on 7/31/24 at 11:25 AM Staff D, Certified Medication Aide (CMA), said on 6/15/24 Staff E, Agency Registered Nurse (RN), informed her about Staff C being on her way and then she left, leaving the facility without a nurse. Staff D recalled that Staff E left at approximately 6:45 AM and Staff C didn't arrive for a couple of hours. Staff D stated she got the residents' blood sugars because it was in her scope of practice, however, she wouldn't be in her scope of practice to administer insulin or assess a resident with a low blood sugar. Staff D recalled having concern with Resident #7's low blood sugar reading as his blood sugar varies a lot from day to day. She recalled that he didn't show symptoms when really low or really high blood sugars. Staff D added she would have referred the blood sugar reading of 65 to the nurse to assess and direct interventions or monitoring. Staff D reflected being nervous about a fall, Resident #2's tracheostomy, and the diabetic residents. She added if Resident #2's tracheostomy came out she couldn't reinsert it, because not within her scope of practice. Staff D stated the expectation is to have a nurse present in the facility at all times.</p> <p>(continued on next page)</p>

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>During an interview on 7/31/24 at 11:45 AM Staff F, CMA, stated she worked the day shift on 6/15/24. She saw Staff E leave the facility and get in a car in the parking lot at 6:45 AM. Staff D informed her they didn't have a nurse in the facility. She took Resident #7's blood sugar and if she had a nurse in the building, she would have notified them of a reading of 65. Then she would give orange juice or whatever the nurse directed her to do. Staff F stated she called the Director of Nursing (DON), however, she didn't answer the phone or respond to the multiple text messages sent.</p> <p>In an interview on 7/31/24 at 11:53 AM Staff G, Housekeeper, stated on 6/15/24 when she arrived to work around 8:00 AM, she learned the night nurse left and the day nurse hadn't arrived yet. So, she notified the Administrator that the facility still didn't have a nurse. Staff G provided a screenshot of the text she sent to the Administrator at 8:25 AM that included: the nurse left at 6:45 AM and so it's been almost two hours without a nurse in the building. At 8:32 AM the Administrator responded: Yes, we already spoke with her. She understood, the facility should always be a nurse on duty 24/7.</p> <p>In an interview on 8/1/24 at 10:53 AM Staff E stated on 6/15/23 she worked a 12-hour shift. At 6:15 AM she called Staff C who told her she overslept and was on her way. Staff E stated Staff C told her to just go ahead and go because she would be in soon. Staff E added she called the DON who also instructed to go ahead and go because Staff C would be in soon, and she, would also be at the facility soon. Staff E responded the expectation is to have a licensed nurse at the facility at all times.</p> <p>During an interview on 7/31/24 at 8:10 AM the Interim Administrator provided documentation that Staff C arrived at the facility on Saturday 6/15/24 at 8:41 AM and the night nurse, Staff E clocked out at 6:45 AM. The review of the staffing sheet documented the facility didn't have a nurse on duty during that time. The Interim Administrator stated she didn't know the facility didn't have a nurse on 6/15/24. She added she would have expected the Agency Nurse to stay and the DON come in when she became aware the facility didn't have licensed nurse coverage. She expected the facility have a licensed nurse in the facility at all times. The Interim Administrator responded the facility didn't have a formal policy regarding nursing staffing, as the facility would follow regulations.</p> <p>Further interview on 8/1/24 at 12:57 PM the Interim Administrator reported the facility did not have a medication administration policy nor a policy on tracheostomy care, but expected a licensed nurse would administer insulin and perform tracheostomy care and suctioning.</p> <p>Review of the staffing agency invoice revealed Staff E clocked out at 6:45 AM on 6/15/24.</p> <p>Review of an Employee Timesheet for Staff C revealed on 6/15/24 Staff C clocked in at 8:41 AM.</p> <p>A facility document titled Nursing Staffing Information revealed on 6/14/24 listed Staff E as the nurse on duty from 6:00 PM until 6:00 AM on 6/15/24. The form listed Staff C as scheduled for the 6:00 AM to 6:00 PM shift on 6/15/24.</p> <p>The form didn't have other nurses on the schedule.</p> <p>The facility provided a typed document that identified 15 residents with a diagnosis of diabetes, with 8 insulin dependent.</p>		

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<p>F 0801</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Many</p>	<p>Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician.</p> <p>35438</p> <p>Based on record review and staff interview, the facility failed to employ sufficient staff with the appropriate competencies to carry out the functions of the food and nutrition service. The facility employed a corporate Dietitian on a part time consultant basis and designated a person who lacked the required certification and/or experience to serve as the Dietary Supervisor. The facility reported a census of 28 residents.</p> <p>Findings include:</p> <p>In an interview on 7/30/24 at 3:30 PM the Dietary Supervisor reported she only worked at the facility for 2 weeks. She explained she worked as a cook at another facility for one year and hasn't completed education on safe service or food handling to prevent food borne illness. In addition, she didn't complete the Certified Dietary Manager certification or enrolled in the program.</p> <p>In an interview on 7/30/24 at 3:09 PM the Corporate Dietitian stated she worked at the facility on a consultant basis and not a full-time basis.</p> <p>In an interview on 3/6/19 at 2:37 PM the Administrator confirmed the Dietary Supervisor didn't have her certification and the facility employed the Dietitian as a part-time consultant.</p> <p>The facility couldn't produce documentation of certification for the Dietary Supervisor.</p>		

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<p>F 0803</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident.</p> <p>35438</p> <p>Based on observations, document review, menu review, and staff interview the facility failed to follow the planned menu for residents on all diet types. The facility identified a census of 28 residents.</p> <p>Findings include:</p> <p>Observation of lunch meal service on 7/30/24 from 11:15 AM through 12:20 PM revealed the unsigned dietary menu intended for Tuesday 7/30/24 lunch listed: cheeseburger on a bun, French fries, creamy coleslaw, scotcheroo bars, and milk. The meal observed to the residents included: Ham salad sandwich, French fries, beets, a cookie and milk.</p> <p>Review of the unsigned Week 1, Regular NAS (no added salt) Tuesday menu for the facility dated for the week that started on Sunday 7/28/24 directed: cheeseburger on a bun, French fries, creamy coleslaw, scotcheroo, and milk.</p> <p>Interview on 7/30/24 at 3:30 PM the Dietary Manager said she didn't know the Dietitian didn't sign the current menu and couldn't locate a signed menu. The Dietary Manager added they made some last-minute changes to the menu and didn't have the Dietitian approve. In addition, she didn't know the Dietitian had to approve the change prior to implementation.</p> <p>Interview on 7/30/24 at 3:30 PM the Corporate Dietitian stated she usually signed the approved menus and if the menu didn't have a signature, then she must have missed it. The Dietitian further stated she expected the facility staff to follow the menu and if they had changes she would review, approve and sign off before they served the meal. She responded no one told her about the changes to that day's menu.</p> <p>Interview on 7/30/24 at 11:15 AM Staff A, Cook, reported they couldn't always to follow the menu, so, sometimes they had to improvise. She said they had to improvise that day because the facility didn't have the items on the menu, so they had to improvise with what the facility had available.</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>35438</p> <p>Based on observation and staff interview, the facility failed to protect food from contamination during meal service. The facility reported a census of 28 residents.</p> <p>Findings include:</p> <p>During lunch service observation on 7/30/24 at 11:22 AM, Staff A, Cook, served ham salad sandwiches, French fries, beets and cookies. Under constant observation Staff A repeatedly touched the ham salad sandwiches with a gloved hand to steady the sandwich while cutting. The continued observation revealed Staff A touched a variety of surfaces with gloved hands including, but not limited to: the outside of the hamburger bun bag, the surface of the counter, the scoop handle, tong handle, serving lids, and her cheek. She repeatedly handled the ready to eat ham salad sandwiches and French fries with the contaminated gloves. The staff directly served the ham salad sandwiches and French fries to the residents.</p> <p>During an interview on 7/30/24 at 3:30 PM, the Dietary Supervisor stated she noticed Staff A repeatedly touch the ready to eat food with contaminated gloves during the meal service. The Dietary Supervisor stated she expected the staff to handle food to prevent food borne illness and not to touch ready to eat food with bare hands or contaminated gloves.</p> <p>The Food Code version 1/18/23 directed that food employees must not touch ready to eat food with their bare hands and must use suitable utensils such as deli tissue, spatulas, tongs, single use gloves or dispensing equipment. The Food Code further required food employees to clean their hands immediately before engaging in food preparation, including before donning gloves for working with food, and as often as necessary to remove soil and contamination in order to prevent cross contamination when changing tasks.</p>