STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165241	A. Building B. Wing	01/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Grundy Care Center	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)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50500 Based on observations, clinical record reviews, facility policy review, resident, and staff interviews, the facility failed to protect a resident from physical and mental abuse for 1 of 3 residents reviewed (Resident #1). Staff A, Certified Nurse Aide (CNA), accepted money, kissed, sent inappropriate pictures via text, and exchanged inappropriate touch with Resident #1. The inappropriate interactions continued until Staff A resigned from the facility. The State Agency informed the facility of the Immediate Jeopardy (IJ) that began as of 10/16/24 on 1/6/25 at 2:55 PM The facility staff removed the Immediate Jeopardy on 1/7/25 by implementing the following actions: a. Resident #1 saw psychiatry on 11/14/24 (prior to self-report), then again on 12/12/24, and is scheduled to see psychiatry again on 1/9/25. Resident #1 will receive on-going psychiatry services as indicated by the provider and as needed (PRN). b. 1/6/25: The facility interviewed all interviewable residents. The interviews determined no additional concerns. c. 1/6/25: The facility interviewed all staff, and concerns raised about Resident #1 isolating himself. The administrator interviewed Resident #1 about these concerns and addressed the concerns d. 1/6/25: The facility educated all staff. The facility provided and reviewed a copy of the abuse policy and procedure for reporting, trauma informed care, and education regarding psychosocial well-being of the residents. e. All newly hired staff and agency staff will complete annual training for trauma-informed care upon hire and be provided with the policy for abuse and abuse reporting. f. 1/6/25: Quality Assurance and Performance Improvement (QAPI review), with on-going audits that include interviews with residents and staff. The facility reported a census of 30 residents. Findings include: (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Resident #1's Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. The MDS revealed Resident #1 utilizing a manual wheelchair independently and requiring supervision/touching assistance to partial/moderate assistance for bathing, lower body dressing, and tub/shower transfers. Resident #1 had a colostomy (a surgical opening in the abdomen to assistance with the passage of stool) and an indwelling urinary catheter. The MDS included diagnoses of neurogenic bladder (trouble with urination), anxiety, bipolar disorder, depression, and post-traumatic stress disorder (PTSD), and paraplegia (inability to move part of the body). Resident #1 reported almost constant pain during the five-day lookback period. Pressure injuries noted on the MDS include one Stage 2 pressure injury and three Stage 4 pressure injuries. Resident #1 received antipsychotics, antidepressants and opioids during the lookback period. The Care Plan Focus initiated 9/17/24 indicated Resident #1 had an activities of daily living (ADL) self-care performance deficit related to paraplegia. Resident #1 liked to be as independent as possible. The Interventions directed the following: a. Assist of 1 with transfers b. Provide a sponge bath daily and showers twice a week. c. Resident #1 self-transfers from his bed to his wheelchair. d. Assist with ADLs PRN. The Care Plan Focus revised 11/20/24 reflected Resident #1 had a mood problem, bipolar II disorder (mood disorder), depression, anxiety, and PTSD. The Interventions instructed the following: a. Resident #1 would receive psychiatric services with a mental health provider approximately every three to six months or as determined by provider b. Offer one on one (1:1) as often as Resident #1 will allow c. Frequent checks d. Administer medications as ordered e. Staff to monitor, record, and report to the primary care provider (PCP) PRN acute episodes of sadness, loss of pleasure, feelings of worthlessness or guilt, change in appetite/eating, change in sleep patterns, diminished ability to concentrate, or change in psychomotor skills f. Staff to monitor, record, and report to PCP PRN risk for harm to self or others. The Skin/Wound Note dated 9/5/24 at 9:00 PM labeled Late Entry indicated Resident #1 admitted to the facility from the hospital with medically complex conditions. He had diagnoses of paraplegia, neurogenic bladder, colostomy status, Stage 4 pressure injuries, chronic pain related to trauma, bipolar type 2, PTSD, sickle cell disease, anxiety, and depression. The assessment described Resident #1 as alert, oriented, pleasant, cooperative, and able to make his needs known. Resident #1 required a wheelchair but could perform transfers by himself with stand-by assistance from staff. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The Health Status Note dated 9/6/24 at 5:25 PM reflected Resident #1 had a good appetite and fluid intake. The note described Resident #1 as pleasant and cooperative with staff. The Health Status Note dated 9/11/24 at 2:17 AM indicated Resident #1 appeared in a good mood. He talked, joked, and laughed with the nurse and other staff members. The Health Status Note dated 9/16/24 at 3:18 PM indicated Resident #1 saw the physician and he received new orders for duloxetine (antidepressant and nerve pain medication) 30 milligrams (mg) daily for chronic pain. The physician gave an order for referral for evaluation for suprapubic catheter. The Health Status Note dated 9/18/24 at 10:15 PM identified Resident #1 had increased pain. He said all of the pain came from taking a shower and that's what made it so much worse. The Order Note dated 9/19/24 at 4:40 PM reflected Resident #1 saw the pain clinic and received adjustments to his pain medications. The Health Status Note dated 9/22/24 at 10:56 AM indicated the staff noted Resident #1 staying in his room all shift. He appeared down and depressed. Recent medication changes interfered with sleep and pain caused his depression to worsen. Resident #1 declined a psychiatry visit. Resident #1 stated talking with staff helped. The staff encouraged therapeutic conversations with people he felt comfortable with and to use socialization as a pain distraction. The Health Status Note dated 9/22/24 at 3:59 PM identified Resident #1 left his room frequently. He had conversations and joked with staff, other residents, and visitors. The Health Status Note dated 9/25/24 at 10:12 PM reflected Resident #1 refused to shower. He said the CNA is too young and it made him uncomfortable. The Health Status Note dated 10/24/24 at 12:28 identified Resident #1 isolated himself in his room that shift and the day before. Resident #1 stated he felt embarrassed due to his colostomy bag smell. The nurse notified the Social Work (SW) and Director of Nursing (DON) of his decline in mood. The Health Status Note on 10/24/24 at 3:31 PM indicated Resident #1 isolated himself, didn't attend the activities he normally attended, and he didn't eat. The SW discussed increasing his depression medications as may not be at therapeutic level. Resident #1 agreed and they scheduled a psychiatry visit. The Progress Note CPT created by Staff J, Nurse Practitioner (NP), on 10/8/24 reflected he had an upcoming appointment with urology to discuss placement of a suprapubic catheter to replace the urinary catheter. The note reflected he participated in facility activities and is very social with other peers and staff at the facility. n. On 10/29/24 at 12:54 PM: Duloxetine increased to 60 mg daily related to increased depression, anxiety, and isolation. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The Health Status Note dated 10/31/24 at 11:47 PM identified Resident #1 continued to have a withdrawn attitude and hardly coming out of his room to socialize that evening. Resident #1 continued to talk in a low slow voice. Staff encouraged resident to come out of room earlier but was not successful. The Health Status Note dated 11/1/24 at 12:39 PM indicated the facility received a fax with a new order for methadone (narcotic for pain) 5 mg twice a day for severe chronic pain due to trauma. The Health Status Note dated 11/2/24 at 10:47 PM reflected Resident #1 continued his new order of methadone (narcotic for pain) 10 mg twice a day for 15 days for pain management. Medication appeared effective as he came out that evening socializing, joking and laughing with staff and other residents. He also agreed to take a shower later due to not having his wound vac at that time. The Nursing Staff Information for 11/2/24 reflected Staff A worked 6:00 PM until 6:00 AM that evening. The Psychiatry Intake Form dated 11/14/24 described Resident #1 as having a depressed affect and withdrawn. They discussed increasing his duloxetine from 60 mg to 80 mg daily. The Health Status Note dated 11/16/24 at 11:27 PM identified Resident #1 in his room, tearful, and complaining of increased depression. The Health Status Note dated 11/17/24 at 11:55 PM reflected Resident #1 in a good mood that evening joking and laughing with staff. The Health Status Note dated 11/18/24 at 11:39 PM indicated Resident #1 appeared to be in good mood as he joked and laughed with staff. The Health Status Note dated 11/19/24 at 11:26 AM labeled as Late Entry written by Staff I, Assistant Director of Nursing (ADON), indicated she learned of alleged abuse between former employee and Resident #1. Head to toe assessment completed with no findings. Resident #1 declined emergency room visit for evaluation and declined facility staff to contact alternative or emergency contact. Staff I notified the administration staff, the police, and attempted to contact the physician. A document titled Iowa Incident Report [NAME] Center Police Dept revealed on 11/19/24 at 3:40 PM, the police responded to a report of dependent adult abuse. The report identified Resident #1 as the victim and Staff A as the offender. Resident #1 reported Staff A attempted to kiss him and he pushed away. Resident #1 also reported that Staff A wanted him to move in with her and she would take care of him. Resident #1 reported the conversations began in October through Facebook. Staff A revealed to the police that a kiss did occur and verified the conversations began on Facebook. The case was reported to the Department of Human Services (DHS) by the police and the Department of Inspections, Appeals and Licensing (DIAL) by the facility. A document titled Iowa Incident Report Supplemental dated 11/25/24 revealed that the Administrator notified the police with further information on the relationship between Resident #1 and Staff A. The Administrator learned through their investigation that the relationship was sexual and occurred during and after working hours. The DHS rejected the report and closed the case. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The document titled Facility Investigative report dated 11/19/24 revealed: a. Staff I, Assistant Director of Nursing (ADON), notified management of alleged abuse after obtaining statements from Resident #1 and Staff A, CNA. b. Staff A terminated employment without notice on 11/18/24. c. A physical assessment was conducted on Resident #1. d. Police was notified of the incident. e. Staff and Resident interviews were conducted. A document titled Interview Statement of Witness dated 11/19/24 at 1:30 PM, labeled 1st statement, signed by Staff I indicated Resident #1 identified having conversations on the phone, text, Facebook messenger and in person. He stated she tried to kiss me and I pulled away or she would have, during a visit after work time. Resident #1 felt Staff A spent more time with him than other residents and other residents commented about how much time she spent in his room. A document titled Interview Statement of Witness dated 11/19/24 at 2:30 PM, Staff B, CNA, reported being aware of a relationship between Resident #1 and Staff A. This included a few hugs and that Staff A was in Resident #1's room a lot. Staff B was not aware of any other detail. A document titled Interview Statement of Witness dated 11/19/24 at 9:30 PM, labeled 2nd statement signed by Staff I, reflected Resident #1 identified October 16th, 2024, as the date he changed his profile on his phone, and Staff A sent a message that stated damn your hot. Resident #1 stated the conversations continued via telephone, text messages, and Facebook messenger. Staff A also started to come into the facility on her day off during the day and in the evenings. Resident #1 stated when Staff A came into his room during work hours, she always closed the door, and the conversations became sexual in nature. Resident #1 stated Staff A was going to leave her husband, file for divorce so they could be together in a trailer that she was going to purchase. She would take care of him, manage his wounds, so he didn't have to stay in the facility forever since he had nowhere to go. Resident #1 stated Staff A initiated the first contact, hugging, and kissing. She requested personal contact to her breasts and between her legs, and he complied. Resident #1 stated Staff A would get mad if he didn't follow her requests. Resident #1 stated Staff A requested having sex, but he stated he couldn't because of the catheter and the wound vac. Resident #1 stated Staff A would get mad when he didn't respond to the messages and would come to the facility to confront him asking, don't I want to be with her anymore? and is there someone else?. Resident #1 stated Staff A sent a text on 11/18/24 to his phone that stated she quit her job so they could be together and they didn't have to hide it (relationship) anymore. On 11/19/24 Staff A texted she (Staff A) talked to Staff I and only told her the bare minimum. She told her they never had any physical contact between them. Resident #1 stated Staff A sent him nude pictures of her on multiple occasions. Resident #1 stated Staff A continued to text I am broken hearted for you, I don't know if I want to live without you. Resident #1 stated he isolated in his room, felt guilty, felt like people were judging him, his depression got worse, and felt like he was taken advantage of. Staff A told him that her brothers acquired personal information about his past. When asked how that happened, Staff A stated she gave her brothers his personal information and they looked him up. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A document titled Interview Statement of Witness dated 11/20/24 at 11:00 AM, indicated Staff C, Cook, didn't know about a relationship between Resident #1 and Staff A. During a call on 11/19/24 Staff A told Staff B, she and Resident #1 kissed and she was going to lose her license. When Staff C arrived to work the same day, Resident #1 told Staff C, Staff A told on herself and that he wanted to talk to them about it. Staff C did not engage in any further conversations. A document titled Interview Statement of Witness dated 11/20/24 at 1:09 PM, Staff F, Medical Records Clerk, detailed a phone conversation with Staff A where she reported she messed up big time. Upon further questioning, Staff A informed Staff F of an inappropriate relationship she had with Resident #1. Staff F ended the conversation at that time and immediately contacted Staff I. The Progress Note CPT created by Staff J dated 11/21/24 indicated: a. Resident #1 had concern of right lower eyelid pain, redness and swelling. b. Resident #1 to have surgery (11/22/24) to place a suprapubic (above the pubic area) catheter. He completed his 14 days of Macrobid (antibiotic) the day before as ordered by urology. c. Resident #1 continued to isolate himself in his room. The psychiatric provider increased duloxetine to 40 milligrams (mg) a week prior. On 12/30/24 at 12:20 PM, observed Resident #1 in his room with the door closed. As Resident #1 sat in his wheelchair with his urinary catheter bag laying on his lap, he smiled as he moved the wheelchair with one hand and spoke on the phone with the other hand. Resident #1 spoke in clear, quiet tones, and looked at the floor during the interview. Resident #1 appeared alert, oriented to person, place and time. Resident #1 left the facility with his sister for a social visit after the interview with the Department of Inspection, Appeals and Licensing (DIAL) surveyor. During an interview on 12/30/24 at 12:20 PM, Resident #1 stated he talked to his brother and he planned to move soon to live with his father, brother, and sister. Resident #1 stated the facility provided everything he needed, including supplies for his catheter and wound care. He added he didn't have any complaints about the facility. Resident #1 stated he met Staff A in September 2024 when he first admitted to the facility and she gave him a lot of care. Resident #1 stated Staff A worked both day and evening shifts. Resident #1 denied a relationship with Staff A and reported it wasn't really nothing. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 1/6/25 at 4:00 PM, Staff A stated she met Resident #1 when he came to live at the nursing facility where she worked as a CNA. Staff A stated she exchanged phone numbers with Resident #1, followed him on social media, would message him via text, and Facebook Messenger. Staff A stated it evolved into a relationship, neither did something the other didn't want. Staff A described the relationship as consensual and she shared texts with the facility management. Staff A stated Resident #1 texted her when she worked to bring him cookies from the snack cart, a hug, and a few kisses. Staff A acknowledged the relationship lasted 2 months, from September 2024 until she quit on 11/18/24. Staff A stated she felt she had to quit as she was not a person to hide stuff and she didn't want to get into trouble. Staff A stated she wanted a relationship beyond the facility, but that didn't work out and I wanted it to be over, so I quit and didn't give notice. Staff A stated on the evening, after she quit, she returned to the facility, went to Resident #1's room, and sat on his bed to talk. Staff A stated Staff H, Registered Nurse (RN) asked her why she quit and why she was there. Staff A stated she returned to the facility the next day to give a statement of why she quit. Staff A told Staff I, me and (Resident #1) had a thing going on and I could not work there no more. Staff A stated Staff I went to Resident #1's room to talk, returned, asked her to leave and not to return to the facility. Staff A stated she received the Dependent Adult Abuse training. Staff A acknowledged Resident #1 was a dependent adult living at the facility and lived there to receive care. Staff A acknowledged that she worked as a CNA at the facility that Resident #1 lived in, where they met after he admitted to the facility, and the inappropriate physical touch happened during her working shift. Staff A stated, It was just kissing that's all. Staff A stated, I messed up, will I lose my license? Staff A reported she spoke to the police. Staff A stated she hadn't returned to the facility and had no further contact with Resident #1. On 1/7/25 at 9:00 AM the Administrator stated Resident #1 received a text from Staff A on 1/6/25 at 5:20 PM that said the facility was going to take her license. The Administrator described Resident #1 as concerned. During an interview on 12/31/24 at 10:53 AM, Staff B, CNA reported Resident #1 was a jokester and Staff A became his Sugar Mama. Staff B took this as a joke since Resident #1 was outgoing and he made us laugh. Staff B stated Staff A was married and she thought Staff A and Resident #1 were friends. Staff A told Staff B she exchanged phone numbers with Resident #1 before Halloween. At the beginning of November, Resident #1 informed Staff B he exchanged phone numbers with Staff A. He wanted Staff A to pick-up something from the store and he gave Staff A money for it. Staff B stated she didn't notice too much going on until Staff A resigned on 11/18/24. The day after Staff A quit, she was observed going into Resident #1's room and sat on his bed. On 12/2/24, Staff B received a text message from Staff A stating she (Staff A) sent Resident #1 a Facebook message on Thursday (11/28/24) that read Baby I miss you. I still care about you and I hope you're doing good. Staff A noted Resident #1 never read or deleted it. During an interview on 12/31/24 at 1:20 PM, Staff C reported Staff A sent her the following text: Resident #1 and I had a thing so I quit. But now he won't talk to me and Staff I knows about it .I don't know what changed with him and he totally broke my heart .I'm just really heartbroken and he just seems to not to give a (f**k). (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 12/31/24 at 2:37 PM, Staff G, CNA, stated Resident #1 and Staff A had a weird relationship, describing it as more intense than with other residents. Staff G stated when Staff A provided showers to Resident #1, it took an hour. Staff G stated when she provided showers to Resident #1, it took 10 minutes as he could do everything himself. Staff G reported Staff A spent more time with Resident #1 about a month before quitting. Staff G stated she noticed Resident #1's demeanor changed, self-isolating in his room, and appeared to be depressed. During an interview on 12/31/24 at 3:20 PM, Staff H, Registered Nurse (RN), reported shortly after Staff A resigned, Resident #1 talked a little about the situation. Staff H stated Resident #1 shared that one time during a shower, Staff A attempted/offered oral sex. Staff H stated her understanding of the conversation, this was not accepted. During an interview on 1/6/25 at 10:30 AM, Staff D, Activities Coordinator, recalled a conversation with Staff A on 11/19/24. Staff A told Staff D she wanted to talk to Resident #1. Staff D took this statement as Staff A wanted to get to know Resident #1, like a relationship. During an interview on 1/6/25 at 11:20 AM, Staff I stated Resident #1 lived at the facility since September 2024. Staff I stated at first Resident #1 kept to himself and didn't socialize a lot, but once he got to know the staff, Resident #1 came out of his room, joked, and laughed. Staff I stated at the end of October 2024, Resident #1 started isolating in his room, not laughing, or joking. Staff I stated the Social Worker set-up a psychiatry visit. Staff I stated after the relationship with Staff A became widely known, Resident #1 still isolated in his room. Staff I stated Resident #1 told her that he felt embarrassed, guilty, ashamed, and felt he taken advantage of. Staff I reported she first learned of their relationship when Staff F, Medical Records Clerk, alerted her on 11/19/24. Staff A returned to the facility that day and Staff I obtained a statement from her. Staff A stated she texted and talked to Resident #1 outside of work. Staff A added they had a few friendly hugs but nothing else. When asked why she wanted to quit, Staff A replied she wanted to quit before anyone found out. Staff I stated after they took Staff A's statement, she talked to Resident #1. Staff I stated Resident #1 acknowledged texting Staff A since October and friendly hugs. Resident #1 reported Staff A tried to kiss him but he pulled back. Staff I stated she conducted a second interview with Resident #1, with him more forthcoming. After obtaining staff and resident interviews throughout the day on 11/19/24, Staff I realized the situation had more going on. Staff I returned to visit with Resident #1 at approximately 10:30 PM. At this time, Resident #1 appeared sad and started crying. Resident #1 shared Staff A sent nude pictures of herself to him. Staff I received permission to see the pictures on his personal cell phone. He felt other residents didn't get the time they needed for care due to Staff A being in his room. Resident #1 reported they kissed multiple times. Staff A asked Resident #1 to touch her between her legs and he did. Staff A asked for sex, Resident #1 replied he couldn't because he had a catheter. Resident #1 reported to Staff I that Staff A had marital problems. Staff A told him she planned to buy a trailer in town so they could move-in together and she would take care of him. After the conversation concluded, Staff I notified the medical director and the rounding nurse practitioner. During an interview on 1/7/25 at 3:00 PM, the Administrator stated Quality Assurance expected the staff identify and report suspected abuse timely. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A document titled Nursing Facility Abuse Prevention, Identification, Investigation and Reporting Policy dated 7/8/24 revealed: a. All residents have the right to be free from abuse, neglect, misappropriation of resident property, exploitation, corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. b. This includes prohibiting nursing facility staff from taking acts that result in personal degradation including the taking or using photographs or recordings in any manner that would demean or humiliate a resident, and prohibits using any type of equipment (e.g., cameras, smart phones, and other electronic devices) to take, keep, or distribute photographs and/or recordings on social media or through multimedia messages. c. Residents must not be subjected to abuse by anyone, including, but not limited to, facility staff, other residents, consultants or volunteers, staff of other agencies serving the resident, family members or legal guardians, friends, or other individuals. d. It shall be the policy of this facility to implement written procedures that prohibit abuse, neglect, exploitation, and misappropriation of resident property. e. These procedures shall include the screening and training of employees, protection of residents and the prevention, identification, investigation, and timely reporting of abuse, neglect, mistreatment, and misappropriation of property, without fear of recrimination or intimidation. f. The training will educate staff on: i. Activities that constitute abuse, neglect, exploitation, and misappropriation of resident property. ii. Procedures for reporting incidents of abuse, neglect, exploitation, or the misappropriation of resident property; and iii. Dementia management and resident abuse prevention.