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	11/20/2025

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, policy review, video footage review and staff interviews, the facility failed to prevent a resident deemed as high risk for elopement exit the building without supervision for 1 of 3 residents reviewed (Resident #1). The facility reported a census of 27 residents. Findings include: The Minimum Data Set (MDS) dated [DATE] for Resident #1 revealed she had a diagnosis of non-Alzheimer's dementia and a memory deficit following a cerebral infarction (stroke). The MDS further revealed a Brief Interview for Mental Status (BIMS) of 5 indicating severe cognitive impairment. The Care Plan revised 6/26/25 revealed Resident #1 had a risk for injury due to wandering and attempting to elope. The Interventions directed the staff to supervise the resident when she was outside the facility.The Incident Report (IR) dated 8/26/25 at 3:30 PM revealed Resident #1 was found walking in the hospital parking lot by an employee and walked back into the building without incident. The Progress Note dated 8/26/25 at 4:04 PM revealed Resident #1 was found outside the facility across the street in the hospital parking lot by a staff member at 3:33 PM. No door alarm had gone off at the facility prior to the resident being found outside the facility. The resident was assisted back to the facility safely. Review of facility policy titled, Elopement/Missing Resident, updated 2/6/23 revealed the purpose of the policy was to secure and maintain resident safety and defined elopement as an incident in which a resident who has impaired decision-making ability leaves the facility without the knowledge or supervision of staff. During an interview on 10/15/25 at 11:00 AM the Administrator revealed they believed Resident #1 exited out the back (east) door following a subcontractor after he entered the code to deactivate the alarm prior to exiting. The Administrator further revealed the facility did not have cameras however she had been in contact with security at the hospital and after he reviewed the footage, he reported it appeared Resident #1 walked out the back door following someone and then walked across the street to the hospital parking lot. During an interview on 10/15/25 at 1:35 PM, Staff A, Human Resources, revealed she had been pulling out of the parking lot on 8/26/25 after getting off work at 3:30 PM and as she looked to the right, she saw Resident #1 in the hospital parking lot across the street. Staff A reported she parked her car and approached Resident #1 who reported she had been looking for her roommate. Staff A reported she told Resident #1 that she knew the location of her roommate and Resident #1 walked back to the facility with her without incident. Staff A further revealed she could see how a visitor would not realize Resident #1 was a resident as she walks very well and looks like a visitor. During an interview on 10/16/25 at 8:40 AM the Administrator revealed all the doors except the door Resident #1 exited when she followed the subcontractor on 8/26/25 had signage alerting visitors to ensure residents didn't follow them out the door. The Administrator stated the door had the signage alerting visitors like the other exit doors but for some reason it had been removed.On 10/16/25 at 1:30 PM, met with the Director of Facility Operations at the local hospital and observed video footage which revealed Resident #1 first observed on the camera at 3:32:05 PM just prior to crossing the street to the hospital parking lot. Staff A had come in contact with the resident at 3:33:33 PM and began walking her back to the facility. The facility corrected the deficiency prior to the start of the survey on (continued on next page)

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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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	8/27/25 by implementing the following: a. Resident #1 placed on 1:1 staff supervision immediately upon returning to the facility. Resident #1 continued on 1:1 supervision until transferred to another facility with a locked unit on 10/2/25. b. Physician and the responsible party were notified of findings. No new orders given.c. Head to toe assessment completed on resident. Assessment within normal limits for residentd. Sign placed on back door and checked for placement on all other doors to remind staff, visitors, or contractors to look behind them when exiting and not to let residents out the door unsupervised.e. Staff educated immediately regarding elopement on 08/26/25.f. Resident Council held 8/27/25 to educate residents on elopement and the importance of keeping all residents safe.g. Elopement reviewed at the Quality Assurance and Performance Improvement (QAPI) meeting.h. Resident #1's plan of care was reviewed to ensure interventions in place to prevent future elopements.i. Additional staff and alert and oriented resident interviews completed.j. Process started to find resident placement in a locked dementia unit due to the fact that Resident #1 won't wear a wander guard and removes the wander guard as soon as it is placed. The wander guard had actually caused the resident to have behaviors when she was wearing it and stated, I feel like a prisoner.k. Will continue elopement drills in the facility to ensure employee compliance.