

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165301	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/02/2025
NAME OF PROVIDER OR SUPPLIER Great River Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1400 West Main MC Gregor, IA 52157	

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 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</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 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, clinical record review, staff interview, family interview, police officer interview and facility policy review the facility failed to ensure the staff maintained all secured exit doors resulting in 1 of 3 reviewed residents (Resident #1), identified as exit seeking, exiting the facility while a staff member who entered allowed the resident to exit. The staff member failed to notify any nursing and/or management staff. The resident then walked 0.8 miles from the facility down an identified highway on an incline from a bluff and into town. The resident had left the facility for approximately 45 minutes before the nursing staff realized he was missing, when the resident's family called the facility and informed the staff. This deficient practice resulted in an Immediate Jeopardy (IJ) to the health, safety, and security of the resident. The facility identified a census of 31 residents. The Iowa Department of Inspections, Appeals, and Licensing (DIAL) notified the facility of the IJ on 11/5/25 at 3:30 PM. The immediacy began on 11/2/25. The IJ was removed per past noncompliance on 11/3/25. The facility removed the IJ through the following actions: *Wander guard placement 11/3/5. *The nursing staff began holding missing resident drills on 11/3/25.* All staff received education on the following policies: missing resident/tenant policy, door alarm response times, prior to their next shift and via a mass text message to all staff. The facility implemented their plan of correction and removed the immediacy on 11/3/25. The scope was lowered from a J to a D. Findings Include: According to a Minimum Data Set (MDS) assessment form dated 10/24/25, Resident #1 had diagnosis that included a non-traumatic brain dysfunction, Hypertension (HTN), Alzheimer's Disease, anxiety, and disorientation. The assessment indicated the resident had a Brief Interview for Mental Status (BIMS) score of 11 out of 15, which signified moderately impaired cognitive skills, Review of Resident #1's Care Plan revealed the following: a. The resident required 24 hour care related to (r/t) Alzheimer's Disease (Initiated 2/13/25). b. At risk for falls r/t pain, weakness and a history of falls. (Initiated 2/13/25). The intervention initiated 9/16/25 revealed, Independent with a front wheeled walker (FWW) for transfers and ambulation. c. Impaired cognition r/t Alzheimer's Disease. (Initiated 2/13/25). The intervention dated 2/13/25 directed staff to cue, reorient and supervise as needed. A Morse Fall Scale dated 10/22/25 at 8:18 a.m. indicated the resident as at high risk for falls. The resident scored 80 on the assessment. It was noted a score between 46 and 125 indicated high fall risk. Per the Fall Scale, Resident #1 exhibited weak fait, and overestimated or forgot limits related to abilities to ambulate safely. An Elopement Incident Form dated 11/2/25 at 7:20 a.m. included the following information: When housekeeper arrived to work at 7:20 a.m. she opened the front door. Resident was [NAME] at the front door and asked the housekeeper to hold the door open for him. The housekeeper held the door open and the resident went outside. Resident was dressed in jeans, sweater, baseball cap, sock and shoes. Resident does often stand at the front entrance and look out the window, however, never attempted to go outside prior. When staff noticed resident was not in his room, Nurse and all of the present staff searched the building for resident, which included every resident room, and then looked outside to see if he was there. Housekeeper then reported she let the resident out the front door upon her arrival to work. Nurse then called 911. Granddaughter then called right after getting off the phone with the police and reported the resident called her and stated he was downtown. Police arrived back to the facility with the resident. Full head to toe assessment done upon arrival back to facility, No injuries. Denies pain. Fingertips cold to the touch due the temperature outside. Resident had his walker with him and his glasses on. The Resident Description section of the Incident Report revealed, I just wanted to get away. Review of a Police Report dated 11/12/25 at 7:16 p.m, for incident date 11/2/25 at 8:06 a.m. included the following: On 11/2/25 at approximately 8:06 a.m., the police officer had been dispatched to the report of a person missing from the care center. The officer later identified the missing person as [Resident #1]. Upon speaking to the staff at the care center, they informed him that one of their staff members held the door open for the resident as he left the care center earlier that morning. The staff stated the resident was not supposed to leave the facility unless a family member picked him up. Then staff then notified the officer the resident's daughter had called the care center and told them the resident had been alone at his son's property at [Address Redacted]. The officer arrived at [Address Redacted] at approximately 8:19 a.m. [Officer] located [Resident #1] standing on the sidewalk across the street from that address. The resident wore a grey sweatshirt and blue jeans. [Resident #1] stated that he walked to that location from the care center and stood on the sidewalk as he waited for his son, [Name Redacted] to pick him up. He (Resident #1) later stated he wished his son would come to pick him up</p>		