| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 165301 | A. Building<br>B. Wing | 08/21/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Great River Care Center | 1400 West Main<br>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) |
|---|---|
| F 0693<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube.<br><br>(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 0693<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, clinical record review, policy review and staff interview, the facility failed to provide a water flush per the physician order, measure the formula amount during feeding set up and raise the head of the bed to 45 degrees in the provision of feeding tube care for 1 of 1 resident sampled (Resident #4). The facility identified a census of 29 residents.Findings include:The Minimum Data Set (MDS) assessment dated [DATE] documented Resident #4 with unclear speech (slurred or mumbled words), rarely/never able to make self-understood, and rarely/never able to understand others. Resident #4 had a long/short-term memory impairment, unable to recall the current season, location of room, staff names and faces, that he was in a nursing home and severely impaired decision-making ability (never/rarely made decisions). Resident #4 exhibited fluctuating inattention (difficulty focusing attention). The MDS listed diagnoses of anoxic brain damage (lack of oxygen to the brain which can cause lasting cognitive effects), dysphagia (difficulty or inability to swallow), gastrostomy status (a feeding tube inserted through the gastric system to provide nutrients and fluids into the body), and profound intellectual disabilities. Resident #4 received 51% or more of total calories and 501 cc (cubic centimeter)/day or more through a feeding tube in the last 7 days while a resident. A Physician Visit Note, encounter date 5/09/25, documented Resident #4 with a profound intellectual disability, chronic anoxic encephalopathy, presence of a percutaneous endoscopic gastrostomy (PEG) tube (feeding tube), oropharyngeal dysphagia (difficulty swallowing) and history of a gastric ulcer. A Progress Note dated 6/21/25 at 1:21 AM documented Resident #4's feeding tube was obstructed and unable to flush to continue the feeding.A Progress Note dated 6/21/25 at 9:48 AM detailed notification to the on-call provider with orders to send Resident #4 to the emergency department (ED) for evaluation of clogged a clogged feeding tube. Staff A, Licensed Practical Nurse (LPN) obtained a Verbal Physician Order to send Resident #4 to the ED on 6/21/25 at 9:59 AM. A 6/25/25 Appointment Note detailed a new feeding tube was placed. The Facility Appointment Physician Response Resident #4 feeding tube had been exchanged, flushed and was working. A New Verbal Physician Order dated 6/25/25 at 2:19 PM ordered Jevity 1.5 Cal/Fiber Oral Liquid Nutritional Supplement, give 1100 ML (milliliter) via feeding tube in the afternoon via pump at 110 ML/hour with auto flush at 15 ML/hour. Elevate the head of the bed (HOB) 45 degrees or higher during feed for two hours after the feeding.An Order Summary Report signed by the Provider on 6/30/25 listed the following physician orders:a. Flush: 150 Milliliters of tap water into feeding tube before the start of feeding. Start date 8/08/25. b. Jevity 1.5 Calories/fiber Oral Liquid Supplement, give 1100 ML via feeding tube in the afternoon via pump at 110 ML/hour x 10 hours with auto flush at 15 ML/hour x 10 hours. Elevate the head of the bed 45 degrees or higher during the feeding for two hours after feeding. Start date 4/15/25. The Nutritional status Care Plan revised 7/11/25 noted Resident #4 received nothing by mouth and needed an alternate feeding method due to aspiration (the inhalation of a substance like food, liquids into the lungs) and a diagnosis of difficulty swallowing. The Care Plan directed to elevate the head of the bed as ordered; provide water flushes as ordered, and to provide tube feeding as ordered.Observation on 8/18/2025 at 12:57 PM and 1:46 PM revealed Resident #4 sat in a recliner in the front lounge muttering non-sensical speech to himself and as staff walked by. During an observation on 8/18/25 at 3:44 PM Resident #4 lay in bed on his back with the head of his bed up approximately 30 degrees. Resident #4 continued to mutter non-sensical speech. Staff B, Registered Nurse (RN) hung a 1000 ML feeding bag on a pole, then poured four 8 ounce (oz) (237 ML) containers of Jevity 1.5 Formula into the feeding bag for a total of of 948 ML. Staff A then poured an unspecified amount out of a fifth Jevity container into the feeding bag topping just over 1000 ML. Staff B voiced Resident #4's orders were to receive 1100 ML, so she just poured a little extra in the bag above the 1000 ML line and that should be about right. Staff B poured 500 ML of tap water into a separate feeding bag. Staff B primed the feeding pump line set and set the pump to 110 ML per hour with a 15 ML water flush every hour. Staff B hooked Resident #4 feeding tube up, then raised the head of his bed up a little more, but not to 45 degrees. When asked if the feeding pump provided a water flush prior to and after the feeding, Staff B responded she wasn't sure and would have to check the physician orders on the water flush. During an interview on 8/18/25 at 4:10 PM Staff B checked Resident #4 flush orders. Staff B scrolled Resident #4's physician orders in the computer and stated she had not completed the 150 ML water flush per the physician order prior to starting the Jevity feeding. An 8/19/25 review of Resident #4 Electronic Medication Administration Record (EMAR) showed Staff B documented off the following physician orders as |