STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165443	A. Building B. Wing	02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Grand Ji Vante	502 Butler Street Ackley, IA 50601

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50874 Based on clinical record review, staff interviews and policy review, the facility failed to treat residents with dignity and respect in a manner that promotes maintenance or enhancement of his or her quality of life for 1 of 1 residents reviewed (Resident #14). The facility reported a census of 28 residents. Findings include: Resident #14's Minimum Data Set (MDS) assessment dated [DATE] listed an admitted [DATE] following a short term hospitalization . The MDS identified the Brief Interview for Mental Status (BIMS) score of 0, indicating severe cognitive impairment. The MDS included diagnoses of stroke (occurs when blood flow to the brain is interrupted, causing brain tissue damage), non Alzheimer's dementia (a group of cognitive disorders that cause memory loss, confusion and other cognitive impairments similar to Alzheimer's disease but caused by different underlying mechanisms), depression and psychotic disorder (a mental health condition characterized by a loss of contact with reality). Staff C, Quality Life Services MDS Coordinator, signed the MDS indicating completion on 12/16/24. The Nurses Note dated 1/15/24 at 6:34 PM documented by the Director of Nursing (DON) indicated she received a call from Staff A, certified nursing assistant (CNA), stating Staff B, CNA, told Resident #14 to shut the fuck up, you're annoying while transferring Resident #14. The staff removed Staff B from the floor. An assessment completed on Resident #14 revealed no injuries and they didn't recollect the situation. During an interview 2/26/25 at 11:26 AM Staff B recalled she assisted Staff A on 1/15/25 to provide care and transfer Resident #14 into her wheelchair. Staff B indicated Resident #14 screamed and hollered. Staff B acknowledged she reminded Resident #14 that she was in a safe place and they were getting her up for supper. Staff B admitted her emotions got the best of her and told Resident #14 to shut up and the F word may have slipped out. On 2/26/25 at 12:05 PM, Staff A reported she assisted Staff B on 1/15/25 provide care and get Resident #14 up for supper. Staff A acknowledged Resident #14 screamed help me and asked for her mom. Staff A reported Staff B told Resident #14 your mom is fucking dead. Resident #14 continued to yell and scream. They transferred Resident #14 to her wheelchair and Staff A transported her to the dining room. Staff A reported she called the DON to report what happened. (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/26/25 at 4:30 PM, the DON acknowledged she received a call from Staff A on 1/15/25 and came into the facility. The DON and Assistant Director of Nursing (ADON) met with Staff B. Staff B admitted she told Resident #14 to shut up. They escorted Staff B out of the facility and terminated her employment for inappropriate behavior. The facility failed to provide the date Staff B received training on Resident's Rights. The Resident Rights policy dated April 2019 instructed the following: a. Residents Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. i. The facility will treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility will protect and promote the rights of the resident. b. Respect and Dignity. The resident has a right to be treated with respect and dignity.

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. 50874 Based on clinical record review and staff interview the facility failed to inform the Long Term Care (LTC) Ombudsman office of a resident transfer from the facility for 1 of 1 resident's reviewed (Resident #9) for hospitalization . The facility reported a census of 28 residents. Findings include: The Nursing Note dated 5/27/24 at 11:28 PM, reflected the hospital admitted Resident #9. The Nursing Note dated 5/30/24 at 11:44 AM, identified Resident #9 returned to the facility. The facility lacked documentation showing the required notification to the LTC Ombudsman of Resident #9's admission to the hospital. During an interview on 2/26/25 at 9:20 AM, the Administrator acknowledged he had the responsibility for sending the notifications to the LTC Ombudsman beginning in June 2024. The Administrator acknowledged the notifications didn't include Resident #9 and would need check with the LTC Ombudsman to see if a former employee sent a notification for Resident #9. During an interview on 2/27/25 at 11:21 AM, the Administrator acknowledged the facility failed to submit the required notifications to the LTC Ombudsman for all residents transferred and discharged during the months of April 2024 and May 2024. The facility failed to provide a policy for required notification to the LTC Ombudsman for resident transfers and discharges.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42441 Based on clinical record review, staff interview and policy review, the facility failed to submit a Level II Preadmission Screening and Resident Review (PASRR) evaluation for 1 of 1 residents reviewed with a new mental health diagnosis (Resident #19). The facility reported a census of 28 residents. Findings include: Resident #19's Minimum Data Set (MDS) assessment dated [DATE] included a diagnosis of post-traumatic stress disorder (PTSD). The MDS reflected Resident #19 received an antipsychotic on a routine basis during the lookback period. The Care Plan revised 11/15/24 indicated Resident #19 received an antipsychotic medication related to PTSD nightmares (military service). The Care Plan goal indicated Resident #19 wouldn't experience any adverse effects of the medication. Resident #19's Medical Diagnoses reviewed 2/25/25 included a diagnosis of PTSD effective 11/10/23. Resident #19's PASRR completed 1/20/23 listed a completed negative Level 1 screening. The PASRR lacked documentation of a known or suspected mental health diagnosis. The clinical record lacked a Level II PASRR evaluation submission following the new mental health diagnosis of PTSD effective 11/10/23. The PASRR Screens/Level 1 & Level II Evals policy, revised November 2024 instructed changes in status are required when a resident receives a new mental health diagnosis. During an interview 2/25/25 at 11:45 AM, the Administrator acknowledged no one completed a Level II PASRR evaluation as he expected regarding Resident #19's new mental health diagnosis of PTSD.

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F 0851 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data. 50874 Based on the Center for Medicare and Medicaid Services (CMS) Payroll Based Journal Staffing Data Report (July 1, 2024 - September 30, 2024) review, facility staffing reports review, and staff interviews the facility failed to submit accurate staff reports for the PBJ Staffing Data Report. The facility reported a census of 28 residents. Findings include: The PBJ Staffing Data Report with a run date of 2/19/25 triggered for excessively low weekend staffing (submitted weekend staffing data is excessively low) and for failing to have licensed nursing coverage 24 hours/day (4 or more days within the quarter with less than 24 hours/day licensed nursing coverage). The report reflected 26 days with a failure to notify for 24 hours/day nursing coverage during July 2024 and August 2024. A review of the schedules for the months of July 2024 and August 2024, revealed nursing shifts covered by facility employees and outside staffing agencies. During an interview on 2/25/25 at 3:18 PM, the Director of Nursing (DON) explained the facility used outside staffing agencies to provide coverage of open nursing hours not covered by facility employees. During an interview on 2/25/25 at 3:37 PM, the Administrator reported the facility switched time clocks from Matrix to Dayforce during the quarter of July 2024 to September 2024. On 2/27/25 at 8:11 AM, the Administrator acknowledged the PBJ reporting didn't reflect the actual staffing compared with the daily nursing schedules. During an interview on 2/27/25 at 8:24 AM, the Administrator acknowledged he submitted the PBJ Staffing Data following the quarter of July 2024 to September 2024. The Administrator revealed the timeclock changed from Matrix during July 2024 and was up and running in August 2024. The Administrator explained they verified outside staffing agency hours through email correspondence with the outside staffing agencies. The Administrator confirmed he didn't validate the PBJ data following his submission to verify data accurately reflected the facility records. Through an interview on 2/27/25 at 8:35 AM, the DON verbalized they determine the staffing requirements by the daily census (the number of residents in the facility) and the resident acuity (the severity of a resident's condition and the level of care they need). The DON acknowledged the facility used 5 different staffing agencies to cover open shifts not picked up by facility employees. The facility failed to provide a policy for accurate submission of PBJ Staffing Data. (continued on next page)

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F 0851 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Staffing Data Submission Payroll Based Journal website found at (https://www.cms.gov/medicare/quality/nursing-home-improvement/staffing-data-submission) updated April 18, 2019, provided information on how data is collected and who to contact for questions. Users are strongly encouraged to take additional steps after uploading their data to ensure a successful submission. Therefore, the following verbiage appears upon uploading data to reflect the recommended next steps: a. Check the My Submissions page. This feature will show the status of the zip file. b. Check CASPER for a system generated PBJ Final File Validation Report (FFVR) within 24 hours. If no FFVR appears, run a PBJ Submitter Final File Validation Report to check your file for errors. c. Run the PBJ 1702D (by Employer, the individual daily staffing report) or 1703D (by Job Type, or the job title report) reports to verify the quarterly PBJ data reflects your records. d. For additional assistance contact the Quality Improvement and Enhancement System (QIES) Help desk at iqies@cms.hhs.gov.