

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165618	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/23/2024
NAME OF PROVIDER OR SUPPLIER Grand Meadows		STREET ADDRESS, CITY, STATE, ZIP CODE 5300 Grand Meadow Drive Asbury, IA 52002	

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 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37072</p> <p>Based on record review, resident and staff interview and policy review the facility failed to prevent a resident from neglect for 1 out of 1 residents who reported abuse (Resident #35). The facility reported a census of 30 residents.</p> <p>Findings include:</p> <p>The Minimum Data Set (MDS) dated [DATE] revealed Resident #35 had a Brief Interview Memory Score (BIMS) of 15 which indicated cognitively intact. The MDS indicated he was dependent for toilet transfers and toileting hygiene. The reason for admission was amputation. Resident #35 had blindness of the right eye.</p> <p>On 04/17/24 at 9:28 AM during an interview Resident #35 stated a staff member became frustrated because he needed to use the call light frequently. She told me I was wearing a depend and to use it, then I don't have to come in here every few minutes. The staff member left and when I went to hit the button it was gone. She came back in for some reason and gave me trouble about wanting to use the buzzer and said oh there it is and it was curled up on the end of the table too far away for me to reach. The rest of the night it was gone and I could not find it again. Someone came in first thing in the morning and said why don't you stay in bed for a few extra hours since feeling bad and then it was past breakfast time and I had wet self several times and when they finally came in it was about time for lunch and I was soaked head to toe and could not find the call light. It made me feel like I didn't matter at all. They told me if it happens again you need to call but I had no way to call since I didn't have my call light. He stated it is pretty demeaning for a [AGE] year old man to have to just wet themselves and then lay in it. At the very least she could have left me a urinal. I felt like I was in the way and she didn't want to do her job.</p> <p>Review of the electronic health record Nurse Progress Notes failed to document anything regarding the incident or follow up with the resident.</p> <p>On 04/17/24 at 1:51 PM the Scheduling Coordinator/Recruiter stated Staff L, Licensed Practical (LPN) agency staff worked the last on 4/8/24 and she was made a Do Not Return on 4/9/24.</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 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 04/17/24 at 2:33 PM the Scheduling Coordinator/Recruiter stated that she was told on 4/9/24 to make Staff L a Do Not Return (DNR) due to being rude to other residents and because she took a call light away from a resident. It was the Director of Nursing and the Administrator who told her to make her a DNR.</p> <p>The facility provided a policy titled Dependent Adult Abuse Prevention last updated 7/14/22 which stated abuse is defines as Denial of Critical Care (Neglect): The deprivation of the minimum food, shelter, clothing, supervision, physical or mental health care, or other care necessary to maintain a dependent adult's life or physical or mental health. Neglect is defined as the failure of a facility, it's employees or service providers to provide good and services to a resident necessary to avoid physical harm, mental anguish, or emotional distress. Resident upon resident assaults could result from lack of supervision and therefore a denial of critical care by the facility caretaker staff.</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37072</p> <p>Based on observation, record review, resident and staff interviews the facility failed to complete a thorough investigation of allegation of abuse to prevent further abuse. The facility reported a census of 30 residents.</p> <p>Finding include:</p> <p>The Minimum Data Set (MDS) dated [DATE] revealed Resident #35 had a Brief Interview Memory Score (BIMS) of 15 which indicated cognitively intact. The MDS indicated he was dependent for toilet transfers and toileting hygiene. The reason for admission was amputation. Resident #35 had blindness of right eye.</p> <p>On 04/17/24 at 9:28 AM during an interview with Resident #35 he states a staff member became frustrated because he needed to use the call light frequently. She told me I was wearing a depend and to use it, then I don't have to come in here every few minutes. The staff member left and when I went to hit the button it was gone. She came back in for some reason and gave me trouble about wanting to use the buzzer and said oh there it is and it was curled up on the end of the table too far away for me to reach. The rest of the night it was gone and I could not find it again. Someone came in first thing in the morning and said why don't you stay in bed for a few extra hours since feeling bad and then it was past breakfast time and had wet self several times and when they finally came in it was about time for lunch and I was soaked head to toe and could not find the call light. It made me feel like I didn't matter at all. They told me if it happens again you need to call but I had no way to call since I didn't have my call light. He stated it is pretty demeaning for a [AGE] year old man to have to just wet themselves and then lay in it. At the very least she could have left me a urinal. I felt like I was in the way and she didn't want to do her job.</p> <p>Review of the electronic health record Nurse Progress Notes fail to document anything regarding the incident or follow up with the resident.</p> <p>On 04/22/24 at 9:58 AM the Administrator stated when I found out about the incident with Resident #35 I immediately reported it to the staffing agency on 4/9/24 and thought this was all I had to do since it was their employee. I told them Staff L, Licensed Practical Nurse (LPN) would be Do Not Return (DNR). I then thought more about it the next day and contacted management company and was informed I needed to report it to the state agency this was on 4/10/24. I thought it occurred the night before the wife reported it. I received a phone call from the wife on 4/9/24 and this is when I contacted the staffing agency. The only thing I did to report it to the state agency was summarize what the wife informed me had occurred. I did not interview any of the staff or follow up with any sort of investigation.</p> <p>On 4/22/24 at 11:01 AM interview with the Nurse Consultant stated he talked to regional staff and basically I can't give you an excuse of why it was not done I am going to tell you I am looking at things across the board. I know it should have been reported within 2 hours of learning of the incident and then investigated which entails who was working where they were working and what times working. We need to self report to Department of Inspections and Appeals and Licensing (DIAL) then the alleged perpetrator is to be separated from the residents.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The facility provided a policy titled Dependent Adult Abuse last updated 7/14/22 it directed the Administrator will report the incident to the Department of Inspections and Appeals (DIA) immediately when notified of incident. The Department of Inspections and Appeals (DIA) must be notified within 2 hours after an allegation of abuse, neglect, exploitation, or mistreatment, including injuries of unknown source and misappropriation of resident property occurs. The Department of Inspections and Appeals (DIA) will be notified within 24 hours if the event that causes the allegation does not involve abuse and does not result in serious bodily injury.</p> <p>After reporting the incident to DIA a comprehensive facility investigation will then be completed within 5 working days of the incident's occurrence. All related documents will be sent to DIA upon request or kept on file for later review by DIA.</p>		

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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>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34821</p> <p>Based on observations, staff interviews and facility policy review the facility failed to secure and supervise access to 2 out of 2 hot steam table surfaces. This failure resulted in the ability of eight cognitively impaired and independently mobile residents to access the areas that held the steam tables, therefore causing an Immediate Jeopardy to the health, safety, and security of the residents.</p> <p>The State Agency informed the facility of the Immediate Jeopardy (IJ) that began as of February 15, 2024 on April 17, 2024 at 3:10 p.m.</p> <p>Facility staff removed the Immediate Jeopardy on April 17, 2024 through the following actions:</p> <ol style="list-style-type: none"> a. The meals will be served in the Bistro common dining room. b. All meals will be served in this location until the barriers can be placed between resident care areas and the kitchen serving area where the steam tables are located. c. The two steam tables were disabled from use to prevent any cognitively impaired residents in the units from possibly getting burned. d. The keys that turn the steam tables on have been removed from the households. e. Education to staff will be provided verbally and on paper using [NAME] Manor's protocol for communication which includes email, text, Alerts & Messages in Matrix, and signage. <p>The scope was lowered from J to D at the time of the survey after ensuring the facility implemented their removal plan. The facility also failed to investigate or do a root cause analysis for a fall with injury for 1 out of 3 falls. The facility reported a census of 30 residents.</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. The Minimum Data Set (MDS) Assessment for Resident #23 dated 4/6/24, included diagnoses of non-traumatic brain dysfunction, anemia, and depression, The MDS's Brief Interview for Mental Status score of 1 out of 15 indicated severely impaired cognition. The MDS identified her independent with ambulation and transfer with an assistive device. <p>The Care Plan for Resident #23 dated 2/22/24, identified impaired decision making related to dementia. The Care Plan directed she will continue to walk independently with the front wheeled walker.</p> <p>The Certified Nurses Aid (CNA) Resource list undated, identified six residents at risk for elopement.</p> <p>(continued on next page)</p>

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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>The Registered Nurse Consultant (RNC) provided his Consultant Summary undated, Environmental Rounds failed to identify the hot steam table top hazard or the broken barrier gate to the B wing kitchenette.</p> <p>On 4/15/24 at 11:30 AM, as Staff K, Certified Nurses Aid opened the lids of the steam table, steam filled the air above the steam table.</p> <p>On 4/15/24 at 2:00 PM, Resident #23 opened another resident room door and wandered in. Resident #18 directed her out.</p> <p>On 4/15/24 at 2:30 PM, Resident #23 wandered the halls and the dining room (DR). Staff were not always in the area Resident #23 wandered. Two other residents also wandered in the DR.</p> <p>On 4/16/24 at 10:02 AM, the B wing kitchenette, failed to provide staff in the area and failed to ensure a barrier across the opening to the kitchenette, the lower part of the wall held a bracket that may have held a gate.</p> <p>On 4/16/24 at 10:30 AM, Resident #23 wandered the halls and the DR in the B wing. Staff not always present to supervise in the area she wandered.</p> <p>On 4/16/24 at 10:30 AM, in the B wing kitchenette the surface of the steamtable felt very hot to the touch. The entrance to the kitchenette lacked a barrier gate.</p> <p>On 4/16/24 at 11:23 AM, the Staff J, CNA left the kitchenette area while three residents sat in the DR at the tables.</p> <p>On 4/16/24 at 11:26 AM, Staff M, Licensed Practical Nurse (LPN), walked through the area and passed by 3 residents that sat in the DR. Two residents sat in their wheel chairs and one independently ambulatory resident sat in a DR chair. Staff M went into the hall.</p> <p>On 4/16/24 at 11:32 AM, Staff J, directed Resident #23 and Resident #14 into the DR area to sit for the meal. The Staff J left the area.</p> <p>On 4/16/24 at 11:47 AM Staff M, LPN told the CNA she needed so go chart something, they both left the DR kitchenette area leaving the residents unsupervised.</p> <p>On 04/16/24 at 12:08 PM, the staff opened the lid from the steam table and the steam rolled up from the steam table.</p> <p>On 04/16/24 at 1:09 PM, Resident #23 wandered the hall and walked right by the open kitchen area and talked to a woman at the table, she pulled up the chair and sat down.</p> <p>On 04/16/24 at 1:12 PM, Resident #10 wandered out and around the tables in the B wing.</p> <p>On 4/16/24 at 1:14 PM, the kitchenette failed to have staff in the area. Food remained on and in the steam table. The steam table checked and it felt hot to the touch.</p> <p>(continued on next page)</p>		

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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>On 04/17/24 at 9:11 AM, the steam tables in the B wing were turned on, the tops felt hot to the touch.</p> <p>On 4/17/24 at 9:53 AM, the top of the steam table in the B wing remained hot to the touch.</p> <p>On 4/17/24 at 1:13 PM, the top of the last steam table well remained hot to touch.</p> <p>On 4/17/24 at 1:20 PM, the facility thermometer used to temp the food in the C wing, placed the thermometer on the surface of the steam table lid and it showed a temperature of 160.3 degrees. Facility staff failed to be in the area to supervise residents.</p> <p>On 4/17/24 at 1:40 PM the Environmental Services Director checked the surface temperature of the steam table top in the C wing and confirmed it was 160 degrees. He then went to the B wing and checked the surface temperature of the steam table top, it reflected a temperature of 155 degrees.</p> <p>On 4/17/24 at 8:45 AM, Staff I, CNA reported three residents in the B wing wandered daily.</p> <p>On 4/17/24 at 1:15 PM, Staff K, CNA reported she worked here for 2 years. She revealed the barrier gate to the B wing kitchenette used to be in place because of a resident who used to go into the kitchenette, but after he passed away it broke months ago and the facility removed it.</p> <p>On 4/17/24 at 1:27 PM, Staff H, Registered Nurse (RN) reported the C wing held seven wandering confused residents. She stated they use the barrier gate at times on the day shift. She revealed the nursing department turned the steam tables on in the morning leave them on for the morning and try to turn them off after lunch at some point.</p> <p>On 4/17/24 at 1:40 PM, the Environmental Services Director reported if a staff isn't in the kitchenette, then the barrier gate needed to be in place. He report the gate in B wing broke a few weeks ago and he failed to have the parts to fix it at this time. He confirmed the surface of the steam table tops were too hot to touch and may result in a burn.</p> <p>On 4/22/24 at 02:25 PM, the Environmental Services Director reported he completed a walk though of the units daily and looked for potential hazards.</p> <p>On 4/23/24 at 9:52 AM the Administrator reported that Environmental Services used an online work order system that staff, residents, or families may submit a request. She continued to report at their daily morning meeting a discussion is held for any maintenance needs and follow up on emails/requests over the past day.</p> <p>On 4/23/24 at 12:28 PM, the Administrator reported she noticed the kitchenette barrier gate in B wing failed to work, but later thought the staff fixed it. She reported her expectation is the staff supervised the steam table area while the stream tables were on and hot. She stated she expected the staff kept the gait closed. The Administrator revealed the Environmental Service Director obtained a work order to fix the B wing gait in February.</p> <p>The facility provided a Work Order dated 2/15/24, reported the gate to keep resident out of the kitchen broke.</p> <p>(continued on next page)</p>		

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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>The facility provided an undated list that identified each resident BIMS and mobility status, the list revealed 8 independently mobile cognitively impaired residents.</p> <p>The facility Equipment Safety policy dated 2013, at point #9 directed that equipment should not be left on when unattended.</p> <p>The Foodwarmers Installation & Operation Manual dated 6/2017, revealed at page 5 General Operation Instruction point #1 All food service equipment should be operated by trained personal. #2 Do not allow your customers to come in contact with any surface labeled caution hot. Page 11 included a Warning: Steam can cause serious burns. Always wear some type of protective covering on your hands and arms when removing lids or pans. Lift the lids or pans in a way that will direct escaping steam away from your face.</p> <p>37072</p> <p>2. The MDS for Resident #138 dated 9/26/23 revealed a BIMS score of 10 which indicates moderate cognitive impairment. The MDS indicated the resident needed substantial assist of staff for transfers and toileting.</p> <p>A incident report dated 9/14/23 at 11:25 PM revealed Resident #138 was found sitting on the floor in front of the bathroom in his room. The walker was near by. Resident was assisted to bed with a mechanical lift and assist of 2 staff. An 8 centimeter by 7 centimeter red area noted to right hip. No external or internal rotation of both lower extremities.</p> <p>The Progress Note dated 9/15/23 at 8:46 AM revealed the resident had increased pain with movement. A physician order was obtained for a portable X ray.</p> <p>The Progress Note dated 9/15/23 7:09 PM revealed the X ray of the right hip showed an irregularity of the cortex of the right hip.</p> <p>The Progress Note dated 9/16/23 at 1:04 AM revealed the nurse spoke with the hospital and Resident #138 was admitted with a fractured right hip.</p> <p>On 04/16/24 at 12:12 PM during an interview with corporate nurse he stated they are unable to locate any investigation or root cause analysis completed after the fall for Resident #138. He stated when the new administrator was hired they found things were not being completed or missing. He stated they spoke to the Director of Nursing at the time of the fall who is also still employed at the facility and she had no recollection of the incident.</p> <p>On 04/18/24 at 2:45 PM Staff G, Registered Nurse (RN) stated Resident #138 got up out of his bed or chair and he fell right before the bathroom in his room. He was toileted before the incident and had been in bed before he got up by himself and fell .</p> <p>On 04/18/24 at 2:53 PM Staff H, RN stated at the time of Resident #138 fall with fracture, I was the Director of Nursing. I am not aware of an investigation or root cause analysis for it. When a fall occurs there should be an investigation and try to determine why the resident fell and then put interventions in place to prevent further falls. I do not recall anything about Resident #138's fall. It would have been the responsibility of the DON.</p> <p>(continued on next page)</p>		

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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>On 04/22/24 at 2:38 PM the current DON stated the responsibility of the investigating for falls would be with the DON but the Administrator has been doing them since he started at the facility. He will be responsible for investigating falls.</p> <p>The facility provided a policy last reviewed 7/18/2017 titled Falls Policy, the policy failed to direct staff to complete an investigation or root cause analysis after a fall. The policy did have a procedure to complete a fall risk assessment within 24 hours of admit, quarterly, and with any significant change and after any fall. Review intrinsic and extrinsic risk factors. Intrinsic risk factors may include: cardiovascular problems, neurological problems, orthopedic problems, psychological and cognitive factors, medications, pain, sleep disorders and incontinence. For extrinsic risk factors, observe how the resident: transfers, ambulates, used the bathroom handrails, and uses assistive devices such as walkers or canes.</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49976</p> <p>Based on observation, policy review, and staff interview the facility failed to date opened foods, use gloves appropriately for serving meals, keep hands off the drinking surfaces of drinking glasses, keep the ice machine clean, and keep the kitchen and household kitchenettes clean in order to serve meals under sanitary conditions. The facility reported a census of 30 residents.</p> <p>Findings include:</p> <p>During a continuous observation of the kitchen on 4/15/24 from 10:00 AM to 10:28 AM the following was revealed:</p> <ul style="list-style-type: none"> A. [NAME] streaks running down the lip of the ice chute in the ice machine B. Egg noodles opened and undated C. Mandarin oranges in a Styrofoam cup covered in plastic wrap undated in the refrigerator D. Food matter on the floor by the heating unit and the two-compartment sink near the refrigerator <p>During an observation on 4/15/24 of the [NAME] Household kitchenette at 10:38 AM the following was revealed:</p> <ul style="list-style-type: none"> A. Food particles in the fridge B. Food splatters and particles in the freezer bins C. Open, undated frozen pancakes D. A moldy calcified water spot on the fridge under the water dispenser E. Orange splatters on the refrigerator door F. Splatters and food particles on the front of the oven G. Crumbs on the stovetop H. Splatters and crumbs inside the oven <p>A follow-up observation of the kitchen on 4/16/24 at 9:50 AM and the kitchenette at 9:58 AM revealed no cleaning or dating of food items had been conducted.</p> <p>During a continuous observation of the noon meal on 4/16/24 from 11:42 AM to 1:29 PM the following was observed:</p> <p>(continued on next page)</p>

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>1. [NAME] Household:</p> <p>A. Staff A, Dietary Services Manager, Staff B, Dietary Aide, and Staff C, Dietary Aide wore gloves and touched utensils, plates, hot well lids, meal tickets, and failed to change gloves before touching buns and plating them. This occurred 9 times affecting 9 residents.</p> <p>B. Water on room trays were transported uncovered. This occurred 3 times affecting 3 residents.</p> <p>C. The handle of a serving scoop was placed in the serving container with the handle directly touching the food. The food was then served to residents.</p> <p>D. A sticky substance coated the floors.</p> <p>2. [NAME] Household:</p> <p>A. Staff A wore gloves and touched utensils, plates, hot well lids, meal tickets, and failed to change gloves before touching buns and plating them. This occurred 15 times affecting 15 residents.</p> <p>B. Room trays were delivered with water and coffee uncovered. This occurred 4 times affecting 3 residents.</p> <p>C. Staff C transported mandarin oranges to a resident's room uncovered.</p> <p>D. Staff C wore gloves, touched a bread bag, and failed to change gloves before she touched the bread, plated it, and transported it uncovered to a resident's room.</p> <p>E. A sticky substance coated the floors.</p> <p>In an interview on 4/17/24 at 9:16 AM Staff A explained he expected Dietary staff to clean equipment right after use, and the ice machines as indicated on the cleaning schedule. He expected the Dietary Aides to clean it as needed if found dirty between scheduled cleanings. He further explained the kitchen staff must clean counters in between making food and at end of the shift. They must sweep and mop at the end of the night. He reported the cleanliness of kitchenettes are the responsibility of the staff in those areas.</p> <p>Staff A explained he expected staff to put gloves on if touching anything ready-to-eat. They must change gloves between touching food and touching something else as the other item may be contaminated. He clarified as long as staff do not touch anything in between they can use gloves to serve bread products. He noted handles of the scoops should not touch food items. He expected all food to be dated upon receiving it and staff must mark the date food is opened and use it within 7 days. He noted staff must not touch the drinking surfaces of glasses and must cover everything on room trays including the glasses. He expected staff to follow all facility policies.</p> <p>In an interview on 4/17/24 at 9:39 AM Staff D, Registered Nurse verbalized she was told the dietary company only serves for 15 minutes and won't clean the tables or kitchenette. She noted household staff were trying to clean things but were not given a cleaning list or schedule.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165618	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/23/2024
NAME OF PROVIDER OR SUPPLIER Grand Meadows		STREET ADDRESS, CITY, STATE, ZIP CODE 5300 Grand Meadow Drive Asbury, IA 52002	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>In an interview on 4/17/24 at 9:46 AM Staff E, Certified Nursing Aide (CNA)/Certified Medication Aide (CMA) reported dietary should be cleaning the counters and sweeping. She explained it often falls on household staff as dietary is not doing it. She denied any instruction from the facility on how to clean or how often. She stated it was getting done whenever they had time. She further verbalized she received no education on serving food or safe handling of foods.</p> <p>During an interview on 4/17/24 at 9:51 AM Staff F, CNA reported household staff are to sweep after meals and third shift is to do a deep clean of the kitchenette. She explained household staff disinfect tables between meals, wipe out the fridge, and clean out the oven as scheduled.</p> <p>During an interview on 4/17/24 at 10:03 AM the DON reported who is responsible for cleaning the kitchenettes depends on the day. Sometimes household staff does it and sometimes the dietary staff do. He expressed it was a team effort between the two of them until ownership of the tasks gets decided. He explained Dietary has their own training on food handling and practices and facility staff take a Food Safety & Sanitation course upon hire. He reported cleaning is not scheduled anywhere it would be charted off on.</p> <p>The undated policy titled Storage directed staff to make sure all goods are dated with receiving date and use-by-date.</p> <p>The undated policy titled Ice Machine Usage instructed staff to clean and sanitize parts of the ice machine considered food contact surfaces according to manufacturer's guidelines.</p> <p>The undated policy titled Policy and Procedure for Activity Handling of Food directed staff to wash their hands and wear gloves or wash hands and use a utensil to pass out food. Clean utensils and proper food handling must be followed.</p> <p>The undated policy titled Cleanliness and Sanitation of the Dining Room instructed staff to handle all dishes, glasses, cups, and flatware by non-food contact surfaces only when assisting with meal service. According to the cleaning schedule, staff are to routinely clean all areas of the dining room, including equipment such as service refrigerators etc. It further explained it is the responsibility of staff from all departments to ensure the dining room is cleaned after meals.</p> <p>The undated policy titled Pest Control directed staff to clean and sanitize the facility thoroughly and regularly. It further directed the Food and Nutrition Services Director to:</p> <ol style="list-style-type: none"> 1. Supervise daily cleaning routines. 2. Monitor completion of all cleaning tasks daily against master-cleaning schedule. 3. Review and change the master-cleaning schedule every time there is a change in menu, procedures, or equipment. 		

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<p>F 0865</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Have a plan that describes the process for conducting QAPI and QAA activities.</p> <p>34821</p> <p>Based on staff interviews, facility record review, and facility policy review the facility failed to ensure an effective Quality Assurance Performance Improvement (QAPI) process to address previously identified quality deficiencies, resulting in repeated deficiencies cited on the current survey and cited in previous surveys. The facility reported a census of 30 residents.</p> <p>Findings include:</p> <p>The Centers for Medicare and Medicaid Services (CMS) 2567 form dated 9/13/22, reflected deficiencies identified for accidents and hazards.</p> <p>The CMS 2567 form dated 2/28/23, reflected deficiencies identified for accidents and hazards.</p> <p>The CMS 2567 form dated 9/14/23, reflected deficiencies identified for accidents and hazards.</p> <p>During the current recertification, complaint, and facility reported incident survey dated 4/23/23, the team identified the same deficiency, Accident and Hazards (F689).</p> <p>On 4/22/24 at 3:19 PM, the Registered Nurse Consultant (RNC) reported he's worked on the accidents and hazards in the building, however he failed to know if the previous team worked on that citation.</p> <p>On 4/23/24 at 12:30 PM, the Administrator reported she monitors and audits the effectiveness of the QAPI process and she confirmed the concern related to the pattern of deficiencies at F689.</p> <p>The facility provided the QAPI Plan dated 12/1/22, that included feedback, data systems, and monitoring that stated the facility will put into place systems to monitor care and utilize data from various sources. It directed it will include tracking, investigating, and monitoring adverse events every time they occur, and actions implemented through the Plan, Do, Study, Act (PDSA) cycle of improvement to prevent recurrence.</p>		