STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165618	A. Building B. Wing	06/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Grand Meadows Senior Living & Health Care	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)
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. Based on observation, clinical record review, resident interview, staff interview, and review of the facilities Resident's Rights form revealed staff failed to treat 1 of 3 residents with dignity and respect during cares as a means to maintain their individual resident rights (Resident #3). Findings include: A Minimum Data Set (MDS) assessment form dated 3.27.25 indicated Resident #3 was admitted to the facility on 3.12.25 with diagnoses that included Chronic Kidney Disease, Osteoarthritis, and Sjorgren Syndrome (autoimmune disease). The assessment indicated the resident had a Brief Interview for Mental Status (BIMS) score of 15 out of 15 (cognitively intact). An interview was conducted 6.11.25 at 12:38 p.m. with the resident and the Administrator present per the resident's suggestion as her story would not have swayed from the truth of what occurred and everyone could have heard about the incident. The resident indicated she had been told by an unknown person to report the incident to the Social Services (SS) designee who went to the resident's room on 3.24.25 first for a routine SS visit/assessment post new admissions to the facility and the 2nd time that day with Staff B, Certified Nursing Assistant (CNA), for completion of a formal grievance form (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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The resident indicated she arrived at the facility a Friday night following a week long hospitalization stay. The resident went to bed but in the middle of the night she felt someone as they pulled her blanket off. The room had been dark so she thought she dreamed the situation and pulled the blankets back up. The situation occurred again so the resident again pulled the blankets up, tucked them under her body and rolled on her side. At that point the covers came all the way down along with her cotton pajama bottoms which were not all the way removed but at this point the resident knew the situation was not a dream. The next thing she knew the nurse pulled her legs apart and tried to take off her panties so the resident held onto them and pulled opposite the staff member which ultimately ended up in the panties having ripped. The resident asked the person that pulled down her blankets what had been going on and the staff member told her a required skin assessment. When the resident asked the staff member the time, she stepped into the bathroom while the motion light lit up and the staff member stated 2:30 a.m. At that point the resident told the staff she had not understood that situation and directed the staff to get the f*&^ (explicit) out of her room. The resident described the encounter as having felt violated and she now knew how a rape victim felt when their perpetrator pulled their cloths off. The resident indicated she just could not understand why the staff failed to announce themselves, turn on the light in the room and/or have tapped on her person as a means to awaken her prior to the removal of the blankets which startled her. The resident indicated after the whole incident she went to the bathroom in her room and took off underwear because she was so scared following the event she accidentally peed her pants. The resident indicated when she informed the SW designee about the situation the SW informed her any further contact by the staff member and the resident would not have been allowed but the next day she came into her room and administered her pills so the situation had not been handled from the facility standpoint. The resident indicated she would have been OK post the incident with the planned no contact however that ended up not to be the case. The resident went on to say, she had been so scared following the event she placed her walker in front of her room door for safety. During an interview 6.11.25 at 1:13 p.m. the SW designee indicated she knew nothing about the torn panties, rather, all she had been told during her grievance investigation were the sheets/blankets had been pulled way back and the resident asked the staff member what hell they were doing. During an interview 6.10.25 at 2:28 p.m. the SS Designee confirmed the resident arrived at the facility on a Friday in March for a skilled stay and apparently the 3rd shift nurse, Staff A, LPN entered her room in the middle of the night and ripped her covers back. When questioned Staff B indicated she attempted to have performed a thorough skin assessment because it had not been completed. The outcome of the situation resulted in Staff A had been given the directive to not work with the resident. During an interview 6.11.25 at 4:11 p.m. Staff B, CNA confirmed she accompanied SW Designee to the resident's room for completion of the grievance form and interview with the resident. Staff B indicated the resident told the SW Designee a nurse on the night shift came into her room around 2-3 a.m. for a skin assessment and ripped off her blankets but the resident never mentioned her undergarments having been exposed however her pajamas were. The resident attempted to pull the blankets back up because of not having been aware of the nurses actions. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Staff B failed to recall if the resident stated the staff separated her legs but she said she felt violated because of the way the nurse performed the assessment and at that time she felt unsafe. Review of the resident's Medication Administration Record (MAR) dated 3.1.25 thru 3.31.25 Staff A, Licensed Practical Nurse (LPN) administered medications to the resident after the grievance was issued on 3. 24.25, 3.25, 3.30 and 3.31. During an interview 6.11.25 at 2:52 p.m. Staff A, Licensed Practical Nurse (LPN) confirmed she had not recalled the resident and/or the incident and she only found out about the grievance on that day (today). A facility summary of events form dated 6.12.25 included the following: On March 24, 2025, during a routine social service assessment, the resident mentioned to the SS Designee of an alleged interaction that occurred on March 22, 2025. The resident reported to her, while she slept, two (2) staff members, which included a nurse and an aide came into her room without any form of communication or direction and started a skin assessment on the resident. The resident claimed they pulled the sheets off her to look at her skin. She also claimed she asked the staff what they were doing, as she attempted to pull the sheet back over her body. Staff replied they a skin assessment. The resident asked the staff why the assessment could not have been completed earlier or later in the morning and complained the staff ignored her. The resident claimed she directed both staff members out of her room and to have not returned without a knock. When the SS Designee performed her assessment it had been when the resident told her what occurred (was on a Monday). Following the assessment the SS Designee asked the resident how things had been going. The resident stated good after the 1st night. That was when a Grievance Form had been completed. The Resident's [NAME] of Rights signed by the facilities Administrator at the time and the Resident 3.21.25 included the following: a. Each Resident had the right to a dignified existence. b. Each Resident had the right to considerate and respectful care with a reasonable accommodation to their individual needs.